

*This article was originally presented as a paper to the Psychoanalytic Psychotherapy Association of Australasia in June, 2003. Publication was invited by the Australasian Journal of Psychotherapy and this is the version submitted for publication.*

## **Generating a reflective space for GPs: working with Balint groups Marion Lustig.**

*“There is always a problem in doctoring – how much strain can one stand and yet keep one’s capacity to think?” (Main, 1978).*

The strains of general practice can be enormous, as reflected by Maine in his 1978 Balint Memorial lecture “Some Medical Defences Against Involvement with Patients”. In Balint groups, GPs experience a reflective space in which they explore clinical material from their practices, with a focus on the doctor-patient relationship. This article aims to introduce Balint groups to a psychoanalytic readership and to situate Balint work as the child of two “parents”: psychoanalysis and general medical practice (Salinsky, 2001).

After defining Balint groups, I will outline how I personally became interested in Balint work. Then I will review some of Michael Balint’s insights into what is the heart of Balint work – the doctor-patient relationship. Next, I’ll describe what actually happens in a Balint group. I’ll outline some of the administrative and organizational contexts for Balint work in Australia. I will conclude with a brief discussion about Balint group leadership. My article will be illustrated with disguised examples taken from Balint groups I lead.

### **Example:**

***Dr A spoke in a soft, sad voice: “My patient is a single man in his mid 40’s. I’ve known him for about 12 years. I don’t like him very much. I’ve worked in 3 different clinics and he’s followed me each time. He has a brother who also attends the practice, and whom I also don’t like very much. He always presents with multiple symptoms and I never feel I’ve really grasped what the trouble is. Initially I saw him for a knee injury at work. He’s quite overweight, and he has developed diabetes and high blood pressure and now fibromyalgia. I’ve never cured any of his symptoms. I don’t understand why he wants to see me. I’ve suggested a more local doctor would be a***

***good idea, but he says he's happy with me. I've suggested he attend a rehabilitation program for his fibromyalgia – but he says he can't see how they'd do anything different from what I'm doing. He's on heavy doses of pain killers and he won't exercise. He has lived in a variety of rented flats, but he always argues with his neighbours and has moved several times because of these disputes. He makes intensely sexist comments which irritate me. Every consultation feels like a dead end. He's argued with every specialist I've ever sent him to, and threatened to sue one of them, I've given up sending him to specialists since it doesn't do any good and only makes my relationship with him more difficult because of his complaints about them. I despair of him. I wish he'd see someone else".***

I think it is fairly obvious to a psychoanalytically informed readership that the key psychoanalytic concepts of the unconscious, transference and counter-transference have something important to offer Dr A in understanding his painful response to this hated patient. And perhaps without these concepts, it is hard to imagine him finding a way of thinking about this patient who, so far, is difficult to bear or to help.

### **What is a Balint group?**

Most readers will know that the Balint group is an educational activity for GPs, named after the psychoanalyst Michael Balint who worked with groups of GPs at the Tavistock Clinic, London in the 1950s (Balint, 1957; Balint et al, 1966). A Balint group consists of a small group of practising GPs who meet regularly to discuss their cases, with a focus on the psychological aspects of general practice and, in particular, on understanding the doctor-patient relationship. It can help GPs not only in dealing with mental health issues but with many of the other difficult situations which occur in general practice. I believe it can help GPs enormously in their challenging and often quite isolated role. I have observed it having a dramatic impact on participants' professional satisfaction (Lustig, 2003).

Since Balint's pioneering work, there has been much development of the Balint group concept (Salinsky, 2002; Salinsky, 2003). Although Balint groups have not been popular in Australia, the Balint group method is well-recognized internationally (International Balint Federation website). Balint groups and societies operate in many countries (for example, Otten, 1998, Rabin et al, 1996, Johnson et al, 2001, Balint Society website, American Balint Society website) and there is a substantial literature (some important examples are Samuel, 1987, Elder and Samuel, 1987, Samuel, 1989; Salinsky and Sackin, 2000; Salinsky and Otten, 2003).

I would like to increase people's consciousness of this work in the psychoanalytic community, and to encourage more people to become involved with what has always been a non-mainstream GP activity but which I believe can make an important contribution to general practice.

### **How I became interested in Balint work.**

I vividly recall my experience in 1976 as a very raw junior doctor at a teaching hospital in Melbourne. I worked over 100 hours per week, carrying enormous responsibility and trying to put my personal life on hold. That workload was a struggle if only because I was so much more interested in my patients as people than in the minutiae of their pathophysiology. I was chided for being slow and inefficient and emerged angry and professionally lonely. The next year I set out as a rather belated adolescent to travel the world.

I had always been interested in the interrelationship between body and mind in a broader way than a focus on mental illness per se. As a medical student, I read Michael Balint's "The Doctor, His Patient and The Illness" (1957) and found it enormously exciting and intriguing. I had heard of the Balint movement spawned by the book. So when I ran out of money and found myself in London in 1979, I sought out a Balint oriented practice where I worked for 12 months, participating in a weekly Balint seminar with other doctors training to be GPs. It was an enormous relief to me after those medical school and residency years to finally have a mentor, the late Jack Norell, who shared and supported my interests and who was highly skilled in the art of using himself in the doctor-patient relationship. Jack had been a participant in one of Balint's groups. He had co-written the fascinating book "Six minutes for the patient: interactions in general practice consultation" (Balint and Norell, 1973) which explored how genuine emotional engagement and indeed, a form of psychotherapy was possible in brief general practice consultations over a period of time. Jack was the Dean of Studies of the Royal College of General Practitioners during the time I worked in his inner London practice. How validating it was to encounter a senior and respected clinician with similar interests to my own!

After a circuitous route, involving extensive postgraduate training to become and then to work as a GP and then retraining and working as a psychoanalytic psychotherapist, my interest in Balint groups re-surfaced. Decades later, I lead Balint groups for GPs and find this a very enjoyable and fascinating application of psychoanalysis.

### **The doctor-patient relationship: the heart of Balint work**

Several doctors have joined my groups having read "The doctor, his patient and the illness" (Balint, 1957) and I have been struck by its powerful impact on them. It is not unusual for people to talk about the book having changed their lives.

The book was a milestone in recognizing how important psychodynamic understanding could be in general practice. Balint rightly saw general practice as a unique discipline with its own difficulties, challenges and advantages. He recognized the power of the doctor-patient relationship in influencing the patient, the patient's symptoms and the therapeutic outcome.

Balint used the famous metaphor of “the drug, doctor”. The most frequently used drug in general practice, according to Balint, was the doctor himself and I quote just to give you an idea of Balint’s unique writing style: “...It was not only the bottle of medicine or the box of pills that mattered, but the way the doctor gave them to his patient – in fact, the whole atmosphere in which the drug was given and taken...” However, he went on, “no pharmacology of this important drug exists yet ... no guidance whatever is contained in any text-book as to the dosage in which the doctor should prescribe himself, in what form, how frequently, what his curative and his maintenance doses should be, and so on. Still more disquieting is the lack of any literature on the possible hazards of this kind of medication, on the various allergic conditions met in individual patients which ought to be watched carefully, or on the undesirable side-effects of the drug ...” (Balint, 1957, p. 1). He described one of the chief aims of his research group of GPs as devising a pharmacology of this drug – the doctor – and, in particular, to describe its “undesirable and unwanted side-effects”. I quote again:

“... it happens not so infrequently that the relationship between the patient and his doctor is strained, unhappy, or even unpleasant. It is in these cases that the drug ‘doctor’ does not work as it is intended to do. These situations are quite often truly tragic; the patient is in real need of help, the doctor honestly tries his hardest – and still, despite sincere efforts on both sides, things tend obstinately to go wrong.” (op. cit. p. 11).

The book goes on to elucidate many aspects of the GP-patient interaction, illustrated with clinical material from his GP groups. I summarize these here, with examples from my own GP groups.

1. The concept ***of the unorganized phase of illness***. A patient having difficulty with a life problem may “offer” one or more illnesses to the doctor, and the doctor’s response, whether it is acceptance, rejection, counter-offer or negotiation may profoundly influence the outcome, whether it is a settling down by the patient into a definite organized illness, with the associated costs involved, or an addressing of the real problems.

***In our first example, Dr A’s patient, the man he doesn’t like very much, “offers” a series of symptoms, none of which seem to be the “real problem”, He has settled down into the organized and debilitating illness of fibromyalgia, the costs of which include chronic pain for the patient and frustration for the doctor.***

2. The common pattern of ***the sequential elimination of physical diagnoses*** by appropriate physical examinations, tests and referrals, without proper psychological examination that might enable a positive psychological diagnosis. A psychological diagnosis thus becomes a diagnosis of exclusion. The patient is seen as having nothing wrong with them rather than a legitimate psychological issue requiring attention. The automatic, mechanical application of this process of

elimination by appropriate physical examinations protects the doctor against missing a possible organic illness, but at the price of establishing a ranking order of illnesses and of patients attached to them. Another danger of this approach is that the doctor may well find an accidental and often irrelevant physical sign which may encourage the patient to organize his illness around it.

**Example**

***Dr B presented a young mother of three children under five presenting with lethargy persisting after the mild anaemia thought to be its cause had been treated. The patient saw her problem as a physical illness and disagreed with the doctor's suggestion that she might be depressed. The doctor was reluctant to probe too deeply, as the patient told her the counsellor she'd seen a year previously had been too personal and gone unnecessarily into the past. Besides, he wasn't a psychotherapist and didn't feel he had the skills to make the psychological diagnosis he suspected. Dr. B mentioned that although he had seen the patient and her two children a number of times, the patient's husband had never attended the practice. Dr B had done all the relevant tests, and tried various medications with no improvements in the patient's symptoms, and he felt quite stuck in knowing how to proceed with this patient who seemed to be genuinely unwell.***

***After the group discussion, Dr B felt more confident about the need to explore a psychological diagnosis. He gently explored the patient's family situation, discovering that the patient's husband had adopted a long-term sick role after a back injury at work. She found this tiring and depressing. Perhaps it was her turn to be ill. After telling the GP all this, she felt much better. The GP continued to keep the question of the patient's past in mind, but didn't unhelpfully push her.***

***Dr B, despite the presence of a physical diagnosis, anaemia, was able to address the psychological issues in a timely enough manner, so that the patient did not "organize" her symptoms around it, nor did the doctor create a "ranking order" in which the relatively unimportant physical illness was seen as more legitimate than the much more important family difficulties. At the same time, the doctor's ongoing relationship with the patient, and involvement with physical treatments, provides him with time in which she can proceed psychotherapeutically at the patient's pace.***

3. To return to Balint, another process he describes he calls ***the collusion of anonymity***, contributed to by doctor, consultant and patient, in which no one doctor assumes responsibility for the overall diagnosis and treatment of the patient. This collusion of anonymity is often accentuated by the perpetuation of the teacher-pupil relationship between the GP and the consultant who may actually be or may stand for a former teacher of the GP in the teaching hospital situation. This teacher-pupil relationship is often ambivalent and not entirely

genuine. In other words, the GP pays lip service to consultants' authority while at the same time experiencing their advice as unhelpful or even destructive. Ideally, the GP should remain in full charge of their patient, handing the patient over to the consultant for a limited time and for a limited purpose. The consultant then takes on the role of expert assistant rather than superior omniscient mentor.

### **Example**

***Dr C started her presentation with the comment: "I don't think there's anything you can help me with in this case – I think I'm doing everything I can". She proceeded to describe an elderly man with schizophrenia and a delusion that he was being observed via a camera in his eye. He was presenting frequently at the Eye & Ear Hospital, requesting surgery to remove the camera, and once or twice a week at his surgery as well, with a long list of identical complaints each time. A psychiatrist friend to whom she had referred this patient discovered she was under a compulsory treatment order, so that she wasn't allowed to change the medication and felt there was nothing further she could offer. Dr C felt that as she, too, couldn't change the medication, she could do nothing further than be readily available for this patient, just being there for him, and accepting his need for frequent contact.***

***Although valiantly attempting to help the patient, Dr C was unwittingly contributing to the collusion of anonymity. She realized during the discussion that there was a case manager allocated to this patient, with whom she had never made contact. Nor did she know who administered the patient's medication under the compulsory treatment order. Gradually there emerged the now obvious and painful truth, that no-one was really carrying responsibility for this very distressed and disturbed patient.***

***4. The unpredictability of the commonly utilized approaches of advice and reassurance, both being expressions of the doctor's common sense, where they are administered without the kind of skilled listening that will reveal accurately the nature of the patient's anxieties. Common sense is seen as a hit or miss affair, unpredictably dependent upon the doctor's own personality and values.***

### **Example**

***Dr D presented a 26 year old male nurse, so worried about some unusual neurological symptoms, coupled with overwhelming anxiety and panic attacks, that he had returned from a working holiday in France to be investigated here. He felt very unwell and was convinced he had AIDS and a brain tumour, despite negative investigations. He had become socially isolated, and spent hours after work, crying in the park, convinced he was going to die. He said he didn't trust doctors, and cited instances in the past of a doctor missing his lung infection and of a traumatic experience of his grandfather's illness and death from cancer. He had returned to his parents' home where his parents were very supportive, but his mother was***

**also prone to panic attacks. Dr D felt that repeating his AIDS test would be counter-productive, as he wouldn't believe the result and it would only lead further physical investigations, increasing the chance of the patient organizing an illness along physical lines and avoiding a psychological diagnosis.**

**The group agreed with the presenter that the "common sense" approach of reassuring the patient he didn't have AIDS, without understanding better the real source of his anxiety, was probably not going to help him and indeed might be counter-productive.**

**5. The capacity to listen**, which requires what Balint called "a considerable though limited change in the doctor's personality". To quote Balint: "While discovering in himself an ability to listen to things in his patient that are barely spoken because the patient himself is only dimly aware of them, the doctor will start listening to the same kind of language in himself. During this process he will soon find out that there are no straightforward direct questions which could bring to light the kind of information for which he is looking. Structurizing the doctor-patient relationship on the pattern of a physical examination inactivates the processes he wants to observe as they can happen only in a two-person collaboration" (Balint, 1957, p. 121).

**6. The special psychological atmosphere of general practice.** Patient and doctor generally have an ongoing, open-ended, sometimes life-long relationship, consisting of numerous threads. The doctor deals with both physical and psychological problems. The relationship may involve physical touch, prescription of medication and writing certificates and reports. The doctor frequently knows and treats other members of the patient's family.

Therefore, although a GP's psychotherapeutic work may have its roots in our familiar concepts of the unconscious, transference and countertransference, the setting or frame is very different to that of the specialist psychotherapist.

### **Example**

**Dr E presented a 16 year old boy from a South American migrant family who had been seriously injured in a fight 2 years previously outside a pub. He had had to have his spleen removed. Since the accident, his mother, to whom he was closest in the family, had left to return to her country of origin. His sister had initially been very supportive of the patient and then also returned overseas. The boy had dropped out of school, was extremely anxious and suffered from migraines keeping him awake at night. This boy had been referred to a psychologist who treated him with relaxation exercises, and he had not continued the treatment. The boy never attended follow-up appointments and presented only in crises with physical symptoms. The migraines had settled down with daily visits and major tranquilizer injections but Dr E was concerned about the boy's anxiety and didn't know how to get him to come back to try and address it.**

***This is a good example of a patient who, at least at the moment, cannot be referred, presents with mainly somatic symptoms, and is clearly in great need of psychological help.***

***In the group discussion, one participant tellingly described “the huge amputation in his psyche” which he felt this boy had suffered. The doctor’s countertransference of intense worry and acute awareness of the lack of continuity in her contacts with the patient, provided clues to the effect of catastrophic discontinuities in the patient’s history. It remains to be seen whether the GP’s increased understanding of the source of her countertransference will make it more possible to engage with this boy within the context the psychosomatic presentation provides.***

***In this case we clearly see how the general practice context, although it is a long way from the so-called neutrality of the psychoanalyst, has advantages as well as disadvantages, such as enabling the GP to treat a much broader range of patients than the psychotherapist - in particular, the ubiquitous somatizing patient who does not recognize a psychological problem and cannot readily be referred. And it enables the GP to move between the physical and the psychological dimensions according to the patient’s readiness.***

***7. The apostolic function.*** To quote Balint: “every doctor has a vague, but almost unshakably firm, idea of how a patient ought to behave when ill... what was right and what was wrong for patients to expect and to endure ... and as if he had a sacred duty to convert to his faith all the ignorant and unbelieving among his patients”.

***For example, Dr F was very distressed when a patient recently diagnosed with a bipolar disorder stopped taking her medication. She told the patient he could not continue to treat her for her psychiatric problem unless she resumed taking it but felt awful about having threatened her in this way.***

***The group helped her identify her underlying anxiety about having a potentially very disturbed, suicidal patient on her hands. Her apostolic function was her belief that patient should comply with her treatment orders.***

***This case illustrates what can often be a pervasive theme early on in the evolution of a Balint group – the struggle to carry professional responsibility but at the same time to face one’s lack of omnipotence (Brock, 1990).***

### **What happens in a Balint group?**

A Balint group is ongoing with the same group of participants over an open-ended period of time, often for about 2 years meeting once a week or fortnight. The meetings usually last 1 and a half hours. Usually 2 cases are discussed at each meeting; in addition, the GPs are encouraged to bring follow-up reports of cases previously discussed. Any patient can be presented, not just patients with mental health diagnoses, but they should be current, ongoing patients. A case may have given the presenter cause for thought, distress, surprise, difficulty, puzzlement or uncertainty.

The doctor is encouraged to present the case in an informal, spontaneous manner and without notes. The doctor attempts to convey the essence of what they are finding difficult in a relatively brief presentation, and to include their own feelings and reactions. Spontaneous responses including metaphors and other associations are encouraged. The case is then discussed by the group. There are various ways of doing this. The model I have been using is that after the initial presentation, the presenter is temporally excluded from the discussion - he steps back, so to speak, and listens as the others discuss the case. The group is encouraged to explore their understanding of the case, with particular emphasis on the doctor-patient relationship. The presenter is invited back into the discussion at a later stage (I first encountered this model at an American Balint Society Leadership Intensive I attended in Pittsburgh in 2002).

This model has several strengths: the presenter has a break from carrying the often onerous responsibility for the case, and the group carries it for him for a while. The model reduces pressure on the presenter and discourages lengthy interrogation of the presenter which is unhelpful and occurs readily if not checked. The model thus protects the presenter. It also gives the presenter an opportunity to reflect about the case without any pressure to come up with solutions.

The Balint approach encourages participation by all group members. The leader creates an atmosphere where participants may experiment and take risks without the pressure to be "right". The approach encourages a diversity of views about the dynamics of the case – discouraging the idea that there is a correct solution to the case. It mirrors the reality of general practice, where time is always in short supply and the information the doctor has about the patient is always limited. The group has to work with the limited information it has, and invariably in my experience, careful listening to the material reveals how much more can be understood than in the presenter's initial understanding of the case (Samuel, 1987; Samuel, 1989). The aim of the group's work is to increase understanding of the doctor-patient interaction, and through this of the patient, not to find solutions or give advice.

One function of the leader, which gradually becomes internalized in the group itself, is to pay attention to the group process. Commonly, for example, a clear

focus on either the doctor or the patient's experience, by the group, with an avoidance of one or the other, emerges, and this can then be drawn to the group's attention. Or a pervasive atmosphere or feeling emerges in the group which mirrors something unspoken about the case.

### **Example**

***With Dr C's case of the elderly schizophrenic man, for example, Dr C seemed to find it almost impossible to be silent while the group discussed the case. In a sense, perhaps, she was not allowing the group to carry the case, even for a few minutes, just as she was unconsciously avoiding responsibility herself for fully carrying her patient.***

***Or with the case I wrote about at the beginning of this article, the patient disliked by Dr A, the discussion focused for a long time on the effect of the patient's unlikeable behaviour on the doctor, and on whether the doctor was ethically obligated to continue treating a patient he didn't like and who didn't seem able to be helped. The group struggled for a long time, unable to define just what was so unlikeable about the patient. It seemed to me they were identifying with Dr A's powerful countertransference feelings of dislike and wish to be rid of this patient, and there seemed to be no space to think about the patient's experience. I felt the group, in sharing Dr A's wish to be rid of the patient, might be echoing the way this patient was using Dr A to evacuate and get rid of something unbearably painful in his own experience, and how this created a powerful and important attachment between doctor and patient.***

It is fascinating that so many ideas from psychoanalysis have been incorporated into contemporary Balint work, even in countries where it has become completely severed from its psychoanalytic roots. These ideas include: the unconscious; the importance of childhood; transference; counter-transference; forgetting; ambivalence; slips of the tongue; metaphors; and the idea that symptoms may have layers of meaning (Salinsky, 2001).

### **Balint groups in Australia**

Balint groups are not widely available in Australia. Those that exist are generally run either privately by individual practitioners, most commonly psychiatrists, or by Divisions of General Practice (I am planning a research project to identify more accurately the current status of Balint work in Australia).

Balint groups have not been utilized much here in the postgraduate training of doctors to become GPs (I ran a pilot group for GP registrars in Melbourne in 2003 and I am aware of some teleconferencing Balint work with registrars in the Northern Territory) (Sam Heard, 2002) This is in contrast to the U.S.A. where nearly half of residency programs incorporate Balint groups for residents (Johnson et al, 2001).

I feel that this could be a good time in Australia for the development of Balint work, for many reasons. There has been an increased focus on mental health issues in the general community, such as Beyond Blue (Beyond Blue website). The federal government in its 2002 mental health budget initiatives increased funding for GPs treating patients with mental health problems (Better Outcomes in Mental Health website). There has been an increasing awareness of the health of doctors themselves (the effectiveness of Balint groups in preventing “burn-out” is discussed in Maoz, 2003). The RACGP has recognized the value of small group learning experiences and explicitly encourages them in its current Continuing Medical Education requirements. Many GPs in Australia feel undervalued and demoralized.

Both Beyond Blue and the government mental health initiatives mandate the use of the time-limited specific treatment modalities of CBT and interpersonal therapy in a way which in my view have a useful but limited place in general practice and may not really address what GPs in their practices find most difficult. GPs have a huge range of treatments to choose from, but without an understanding of transference and counter-transference as they arise in the doctor-patient relationship, they struggle to put them into practice at times. The Balint approach aims to foster this understanding so that GPs are freer to tailor treatment to the needs of each patient.

Empowering GPs to be more skilled at psychological work does not set them up in competition with psychotherapists. The scope of their work is much broader than that of a psychotherapist and they must manage many patients for whom referral is either inappropriate or unsuccessful. I would argue that if GPs are better able to engage with their patients psychologically, they will be better placed to make referrals to psychotherapists where appropriate.

There are many reasons why it can be quite difficult to get GPs involved in Balint groups, even though those who do participate are generally highly enthusiastic. GPs are often overworked, and as a group feel undervalued and underpaid, so they find it difficult to make the time for an ongoing commitment. There has not been a culture among GPs of anything much resembling supervision. Most CME activities do not involve detailed self disclosure of the participants' work, nor do the vast majority of CME activities involve an ongoing commitment. Many CME activities are sponsored by either Divisions of General Practice or drug companies and do not involve a charge for the GPs and Divisions of General Practice may be reluctant to fund an activity that is labour intensive and of long duration. And although many GPs have heard of Balint's book, most are ignorant about what Balint groups are.

One could certainly speculate also about how the culture of medical education and indeed the personalities of doctors impact on doctors' willingness to participate in Balint groups, which challenge a doctor's position of being the one with all the answers.

I believe there is an argument for providing time-limited Balint group experiences as a way of giving GPs a taste for the Balint approach. This was done successfully in Melbourne, for example, by the Monash University Department of Psychological Medicine in 1999-2002 as part of a 5 session course on GP counselling. Another model for Balint work is the residential Balint conference. This occurs on an annual basis in Oxford, for example (Jones and Salinsky, 1993, Balint Society website), and is an opportunity to involve doctors who do not have access to an ongoing group and for the discussion of leadership issues. Balint group experience could also be incorporated in other GP residential conferences where GPs would be invited to participate in a series of Balint group experiences over the duration of a conference (this will be done in the forthcoming RACGP National Convention in Melbourne in 2004).

### **Leadership**

A Balint group is facilitated by a trained leader (Johnson et al, 2003). The leader must be knowledgeable about both psychological processes in individuals and groups and about the unique setting of general practice. In Australia up until recently, I believe they have mostly been led by psychiatrists. Overseas, although Balint group leaders were initially psychoanalysts, currently interest among psychoanalysts has been very small, and leaders have in recent years mostly come from the ranks of GPs themselves. GPs often, however, co-lead groups with someone from the mental health field, and working with a co-leader can greatly enhance the leader's capacity to hold the boundaries of the group, keep the group appropriately focused and make best use of the group process. Training for Balint leadership generally involves one or more of the following: substantial experience as a group participant, working with an experienced leader as a co-leader, supervision from an experienced leader, appropriate reading, and attendance at leadership workshops (for example, the American Balint Society runs excellent Balint Leadership Intensive workshops twice each year). Some countries have formal accreditation procedures for Balint group leaders (for example, see American Balint Society website). In Australia there are no formal training programs and in my experience the term Balint group has often been used very loosely and erroneously to refer to any small group discussion for GPs where mental health issues are the focus. I am currently involved with a project in Melbourne in which two Divisions of General Practice have obtained funding to train GP co-leaders.

Tom Main provides a fitting conclusion to this article:

“The strains of trying to understand the *distress of people* rather than merely objectively observing *pain in various conditions* can be immense; yet it is only by subjectivity with all its strains that we can experience our own lives and joys and pains, and the joys or pains and the livingness of others, and thus begin the task of understanding people and their troubles” (Maine, 1978).

## **References**

American Balint Society website: <http://familymed.musc.edu/balint/index.html>

Balint, M. (1957). *The doctor, the patient and his illness*. London, Pitman, 1957; 2<sup>nd</sup> edition Edinburgh, Churchill Livingstone, 1964, reprinted 1986.

Balint, M., Balint, E., Gosling, R. and Hildebrand, P. (1966). *A study of doctors*. Tavistock Publications Ltd.

Balint, E. and Norell, J. (Eds.) (1973). *Six minutes for the patient: interactions in general practice consultation*. Tavistock Publications, London.

Balint Society website: [www.balint.co.uk](http://www.balint.co.uk)

Better Outcomes in Mental Health website:  
<http://www.health.gov.au/haf/budget/mentalhealth.htm>

Beyond Blue website: <http://www.beyondblue.org.au/site/>

Brock, C. (1990). Gearing Balint group leadership to resident professional development. *Family Medicine*, 22:4, 320-1.

Elder, A. and Samuel, O. (1987) *While I'm here, doctor; a study of the doctor-patient relationship*. Tavistock, London.

Heard, S. (2002). Personal communication.

International Balint Federation website:  
<http://www.internationalbalintcongress.de/frame.htm>

Johnson, A., Brock, C. and Hamadeh, G. (2001). The current status of Balint groups in American family practice residencies: a ten year follow-up study. *J. Balint Soc.* 29.

Johnson, A., Nease, D., Milberg, L., Addison, R. (2003). Essential characteristics of effective Balint group leadership. In Salinsky and Otten, op. cit.

Jones, E. and Salinsky, J. (1993). Assessing the effect of a Balint weekend. *Education for general practice* 4, 111-116.

Lustig (2003). Peer support: Balint groups as a reflective space for GPs. PARC Newsletter (Primary Mental Health Care Australian Resource Centre), Flinders University, S.A.

Maine, T. (1978). Some medical defences against involvement with patients. *J. Balint Soc.* 7, 3-11.

Maoz (2003). Balint groups as a way to prevent “burn-out” in physicians. In Salinsky and Otten, op. cit.

Otten, H. (1998). Balint work in Germany. *J. Balint Soc.* 26, 16-19.

Rabin, S., Herz, M., Stern, M., Vaserfier, I., Belakovsky, S., Mark, M. and Ribak, J. (1996). Improving the professional self-efficacy cognitions of immigrant doctors with Balint groups. *Israel Journal of Psychiatry and Related Sciences* 33, 253-9.

Salinsky, J. and Sackin, P. (2000). *What are you feeling, doctor? Identifying and avoiding defensive patterns in the consultation.* Radcliffe Medical Press Ltd., Oxon.

Salinsky, J. (2001). 14<sup>th</sup> Michael Balint memorial lecture: psychoanalysis and general practice; what have the Romans done for us? *J. Balint Soc.* Vol. 29, 24-30.

Salinsky, J. (2002). The Balint movement worldwide: present state and future outlook: a brief history of Balint around the world. *The American Journal of Psychoanalysis*, vol. 62, no. 4.

Salinsky, J. and Otten, H. (eds.) (2003). *The doctor, the patient and their well-being – world wide: proceedings of the thirteenth international Balint congress Berlin 2003.* The International Balint Federation and Die Deutsche Balintgesellschaft. Ruckzuckdruck, Celle.

Salinsky, J. (2003). History of the Balint movement. In Salinsky and Otten, op. cit.

Samuel, O.W. (1987). Aims and objectives of Balint training. *J. Balint Soc.* 15.

Samuel, O.W. (1989). How doctors learn in a Balint group. *Fam. Pract.* 6, 108-113.