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Psychosomatic Medicine and Balintwork

Luxury, nonsense or a reasonable way of thinking?

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Psychosomatic Medicine is defined as a manner of looking at the illness and the ill person in a special way: open for the discovery that psychic and social circumstances are as relevant for the development of the illness as bodily factors.
This point of view is not new. From old history up to the 19th century this way of thinking in medicine went without saying. In the second half of the 19th century recovering Psychosomatic thinking was a reaction to the scientific development, which was enormous: the success in cellular pathology, bacteriology, physiology, surgical techniques etc led to a mechanist model of the human body as a complicated machine.
Freud and his disciples – Michael Balint was one of them – gave rebirth to the word “Psychosomatic”, developed the Psychoanalytic method and tried to find out how much the so called “talking cure” could add to heal bodily symptoms with the background of a psychic conflict.
And it was Michael Balint who saw this very clear and invented a method to train doctors in this skill, to use their relationship to the patient for a more successful outcome.
The bio-psycho-social model – so called by George Engel in the 1970ies - replaced the mechanistic model and helps us understand more about the origin, processing and treatment of somatic diseases. Research shows how important interpersonal relationship is for diagnosis and treatment.
The experience with traumatization especially after the Second World War led to new ideas and theories – e.g. behavioural theory, stress theory, systemic theory - about the genesis of psychosomatic diseases and their treatment. Out of the different theories, different methods of therapy were developed, like psychoanalytic, psychodynamic, systemic and behavioural therapy.
Today Neurobiology helps us explain how this might work.

When I started my medical studies in Göttingen in 1964 there was a lecture about Psychosomatic Medicine held by Werner Schwidder, which fascinated me. Teaching Psychosomatics was voluntary and not yet common in these days. Victor von Weizsäcker had brought the idea to Heidelberg and Alexander Mitscherlich opened an "Institute for Psychotherapy" in Heidelberg in 1950. 20 years later, in 1970 Psychosomatics, Psychotherapy, Medical Psychology and Sociology became obligatory subjects in Medical Education in Germany. Thure von Uexküll is one of the first and most famous directors of a Psychosomatic Department at the University of Ulm. He wrote a textbook on Psychosomatic Medicine, which has been revised 6 times by now, but still is based on his ideas and his description of an "integrated medicine".

Since I heard these lectures in Göttingen, a question followed me all the years during medical school: what do you offer a psychosomatic patient when you try to take his bodily symptom away from him? What is the consequence of showing him that his conflict is the origin of his symptom? Is the patient happy with this news? Can he leave the symptom behind and find a solution for his conflict? How could I help him to do so?

I was already working as a GP and the same questions were still in my mind. Then I found very interesting thoughts and answers to my questions in Balint's papers.

Balint: "Conditioned by their training, doctors in general choose first among the proposed illnesses a physical one, because they can understand it better, they have learned more and so know more about it, and they can express their findings more easily and more precisely. This almost automatic response might – and quite often does – lead to a great number of unnecessary specialist examinations and to prescribing unnecessary medicines."

This was written in 1955. It is still up to date. Nothing changed in general. Nowadays we have more unnecessary examinations and prescribing than ever. The cost for it is immense.

Balint: "… if doctor and patient stick to the bodily symptoms and do not look behind, if they both search for a proper illness and then agree on it, the psychosomatic disease will become chronic and the inner conflict of the patient stays hidden."

Yes, this was my experience in General Practice. But also the other one which Balint described like that:

Balint: “The opposite danger however, is also present. The doctor might be tempted to brush aside all physical symptoms and make a bee-line for what he thinks is the psychological root of the trouble. This kind of diagnostic or therapeutic method means that the doctor tries to take away the symptom from the patient and at the same time to force him to face up consciously to the painful problems possibly causing it. In other words, the patient is forced to change his limited symptoms back into the severe mental suffering which he tried to avoid by a flight into a more bearable physical suffering.”

Finally I understood my conflict, my responsibility for the patient, being fascinated by psychosomatic thinking – and the danger which it includes.
And I understood that I had neither the time nor the tools to treat psychosomatic patients properly in my GP practice, where I had “6 minutes for the patient” (which is the title of one of Michael Balint’s books). On the other hand it was very important not to stick to the bodily symptoms and produce chronic diseases.
I had to find out about my possibilities to be aware of the psycho-bio-social background of the patient’s complains and symptoms. I wanted to learn how to use my time and tools as a GP like listening with the third ear, asking the right questions, perceiving the patient as a whole person.
That was when I started to do Balintwork as a member of a group of colleagues with different specializations, like GPs, psychiatrists, paediatricians and internal medicine. Our group leader was a psychiatrist, well educated in psychodynamic thinking. This group still exists for more than 25 years, and we still get a lot out of this work together.
In Balintgroups we use the analytic method of looking at the doctor-patient-relationship to understand more about “the doctor, the patient and the illness”, (which is the title of Balint’s book about his research.)
One of the members of the small group presents a case, better to say: tells the story of one of his patients. (S)he does not use any medical notes, taken in his office, but reports on his patient and their meetings out of his memories. He talks about the illness and the symptoms, the patient’s emotions and about his own feelings towards the patient. Mostly this takes about 10 to 20 minutes. Afterwards the others may ask him questions. Then the group-leader asks him to lean back and

relax and listen to what the group members feel and think about the doctor-patient-relationship.
Whatever is fantasised can help to clarify. Pictures arise, fairy tails may come up, and symbols are used. Nothing is wrong. “Think fresh, think freely” and “Have the courage of your own stupidity!” Balint encouraged the group members. Every idea might give a hint on unconscious contents of the story.
“I looked at the report of the presenter as if it was a dream” Balint said, “and the thoughts of the presenting doctor as well as the comments and ideas of the group members were treated like free associations.”
The case presenter can look at what is going on from a distance. He will find new aspects, his blind spot might be enlightened, he can find out what made it so difficult to get along with his patient.
Sometimes he may think that some thoughts are crazy and far away from his reality. The group is like a prism or a magnifying glass. It shows all the different colours of the relationship and may focus what the presenter did not look at before.
All group members in the course of time gain the ability of a more analytic observation; they are able to go forth and back from emotional experiencing to a rational reflecting position.

The group-work has elements of a self experience-process, not only for the presenter but for all group members; they all get to know more about themselves without talking about their privacy. The focus in the group is not the personality of the doctor and his private life but the doctor-patient-relationship and the understanding of the patient’s signals, symptoms and conflicts and the doctor’s unconscious answers.
At the next meeting the presenter gives a feedback. Often it is told, that the patient seemed to be quite different at the next appointment, “as if he had listened to what was said in the group session”. The communication between doctor and patient becomes easier and more effective, the compliance gets better. It is a relief for both.
The feedback is a valuable ingredient of ongoing groups.
Medical doctors, who work in a Balint-group, develop a more analytic way of thinking, they are more aware of their personal influence, they reflect more, and they can listen better and get to the roots. There will be a “slight but important change in the personality of the doctor” (Balint) after at least one year of Balintwork, as investigations show,

which turns out to become an advantage for the patient's and for the doctor's well-being.
In Germany we organize weekend workshops for doctors of all specializations. Balintwork is obligatory in the training of GPs, Gynaecologists, Psychiatrists and Psychotherapists. Some of them are not happy to come in the first place. But most of them leave the seminar impressed and with new ideas.
We ask the participants of our Balint weekend workshops to write down one sentence to the question: "what do you take home?" And I want to give you some examples of the answers we got:

- "Now I know: I am not alone with my fears and worries and I dare to express my feelings concerning the patient."
- "I am encouraged to listen to the patient, when he wants to open up and talk about his background"
- "My routine was questioned, and I got a lot of stimulation and encouragement."
- "Calmness to manage my daily work where I have to see so many patients."
- "I got a lot of new ideas for my patients"
- "Better I listen and talk to patients than trying to convince them of my ideas."
- "We also discussed social and political problems in the group and I was impressed how much influence this has on the patient's disease and on the doctor-patient-relationship."
- "The doctor-patient-relationship is more complex than I ever thought"
- "Scales fell from my eyes: my "difficult" patients are mostly the psychosomatic patients."

We are trained to do evidence based medicine. Is it contradictory to emotion based medicine? Or does it go together?
Our next Balint Congress which will be held in **Lisbon/Portugal** this year in September tries to given an answer. It has the topic: "Medicine, Evidence and Emotions 50 years on…"
Balint published his book "The doctor, his patient and the illness" in 1957. What happened with the doctor-patient-relationship since then?

For more than 30 years the Ascona Balint Prize has been given to medical students from all over the world, who describe their own experiences with meeting patients during their studies. They focus on

their emotions and reflection. Often they were taught to defend feelings like anxiety, anger, sadness or helplessness. Those suppressed emotions come back in some way, maybe as a psychosomatic symptom, as a loss of energy and happiness or as a cynical attitude.
Besides the important scientific knowledge which medical students have to absorb, we have to make room in medical education for talking about emotions, about transference and counter transference, about defence and empathy and about the importance of the doctor-patient-relationship, the “doctor as a drug”, as Balint put it.
An excellent technical education and equipment is the one important thing in our profession, a profound knowledge of the bio-psycho-social connections and of the importance of the doctor-patient-relationship is another.
Our work as doctors should be adequate for the patient and satisfying for ourselves. And I am convinced that psychosomatic thinking is not a time consuming luxury, it is a reasonable and necessary basis for our work, the relation to our patients and the treatment of their illness.

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