Karl Miller, MD  
Editor, Letters to the Editor Section

Editor's Note: Send letters to the editor to MillerKE@erlanger.org or to my attention at Family Medicine Letters to the Editor Section, University of Tennessee, Chattanooga Unit, Department of Family Medicine, 1100 East Third Street, Chattanooga, TN 37402. 423-778-2957. Fax: 423-778-2959. Electronic submissions (e-mail or on disk) are preferred. We publish Letters to the Editor under three categories: “In Response” (letters in response to recently published articles), “New Research” (letters reporting original research), or “Comment” (comments from readers).

In Response

Balint Commentary Questioned

To the Editor:

I would like to respond to a number of points made in the commentary by Roger Bibace, PhD.¹

Dr Bibace says that Michael Balint disapproved of the idea of “reassurance and support” for group members. I think he both misquotes and misrepresents Balint here. Balint disapproved of “advice and reassurance” for patients and said that the only person reassured in such a process might be the doctor. Only once does he couple the word “support” with “reassurance.”

When Johnson et al.⁴ talk about the group leaders providing support, they surely mean that the group has to be a safe environment where the doctors can feel free to talk about their feelings and look at their defenses (when and if they wish to do so) without being humiliated. It is clear from Michael and Enid Balint’s writings that they considered this sort of “support” for group members of paramount importance.

If we look at the discussion of group leadership in The Doctor, His Patient, and the Illness (Appendix 1, “Training”)⁵ we find:

Perhaps the most important factor is the behavior of the leader of the group . . . By allowing everybody to be themselves, to have their say in their own way and in their own time, by watching for proper cues—that is, speaking only when something is really expected from him and making his point in a form which, instead of prescribing the right way, opens up the possibilities for doctors to discover for themselves some right way of dealing with the patient’s problems—the leader can demonstrate in the “here and now” situation what he wants to teach.

Dr Bibace goes on to accept that some “support” for the group members may be necessary, but it must be balanced with something that he calls “probing self-reflection.” Who is doing the probing here? Presumably the group leader. But this is not a part of the culture of authentic Balint groups and was never the Balints’ intention, as can be seen from the quotation above. Although psychoanalytic ideas informed the work, the Balints never tried to psychoanalyze their group members or interpret their defenses. The other group members may go in for a bit of probing, but the job of the leaders, as Johnson et al point out, is to encourage the probers to do a bit of self-reflection themselves. Self-knowledge in Balint groups is something that comes slowly and always at a pace that is right for the particular group member. The main objective of the group is to help the doctor be aware of the emotions aroused in him/her by his/her patients and to find better ways to help them.⁴

On the issue of how much psychoanalytic training that leaders require, this is still a matter of some controversy in the International Federation. However, we are all agreed that the way in which the leader conducts the group is much more important than the theoretical basis of his psychological training.⁵

Dr Bibace questions the value of certification of leaders by the American Balint Society (ABS). I would answer that the leader training and certification process developed by the ABS is a very detailed and careful one that provides for both evaluation and supervision of a new leader’s work. Certainly there will be effective group leaders who have not gone through the process, but how can we know this if we have not seen them at work?

John V. Salinsky, FRCPG
London, England
Editor, The Journal of the Balint Society (London)
New Research

Adherence Among Mexican Americans With Type 2 Diabetes: Behavioral Attribution, Social Support, and Poverty

To the Editor:

Introduction: Mexican Americans who view their own behavior as a cause of their diabetes may take a more active role in self care. Social support may also be related to adherence, although evidence for this comes from research with non-Hispanic groups and only one qualitative study of Latinos. This pilot study’s objectives were to test these hypotheses: (1) Individuals who describe their own behavior as a cause of their diabetes will rate themselves as more adherent with American Diabetes Association (ADA) recommendations and (2) Social support is related to self-rated adherence.

Research Design and Methods: This Institutional Review Board-approved investigation was conducted at a community health center in northern California. Mexican Americans with type 2 diabetes participated in a 30-minute interview, in Spanish. Assessment of social support for the 76 participants included questions similar to those described by Tillotson et al. Patients rated level of support from family, friends, or other on a scale of 1 to 5. The Diabetes Activities Questionnaire (TDAQ) (13 items) measured patients’ self-reported adherence with diabetes recommendations, with questions about diet, exercise, medication, and self monitoring of blood sugar. Participants were also asked what they believed caused their diabetes.

Results: Of the 76 participants (58 female, 18 male; ages 27 to 80 years), most had very low socioeconomic status, low levels of education, and inadequate or no medical insurance. Most (87%) were born in Mexico, and 78% spoke Spanish only. Most (85%) had been prescribed pills, insulin, or both, but few could afford to see a doctor or buy prescriptions. Therefore, some participants used folk treatments (herb teas, cactus plants, and urine) in addition to, or in place of, prescribed medications. Random blood glucose levels ranged from 87 to 786 mg/dL (mean=246 mg/dL). The mean fasting blood glucose was 207 mg/dL (range 101–522). Hemoglobin A1C values ranged from 5.4% to 16.8% (mean=10.0%). For patients whose height was recorded, the average body mass index was 31.

Individuals who described their own behavior as a cause of their diabetes did not rate themselves as more adherent. Only 28% of patients described behavior as a possible cause of their diabetes, e.g., drinking coffee with too much sugar, working too much without eating, drinking too much water at night, drinking too much beer, and eating too much candy. Most respondents believed that their diabetes resulted from choices outside of their control: 32% gave hereditary explanations, and 61% attributed their diabetes to susto (fright or shock caused by a prior traumatic event). Attribution of diabetes to susto was unrelated to degree of adherence.

Self-rated adherence was related to both the degree (P<.01) and source of social support. The spouse was the most supportive person for 39% and other family members for 39%. Other people outside the immediate family, including doctors or friends, were identified as most supportive by only 15%, and 7% did not perceive any supportive person in their lives. Patients with supportive family members had higher levels of adherence than did patients whose major support was outside the family (P<.013).

Conclusions: In contrast to previous reports that 72% of respondents believed their diabetes was caused by past behavior, only one third of our sample reported the same belief. Further, most respondents in our sample believed that a past traumatic event (susto), rather than their behavior, was the primary cause of their diabetes. These results are remarkably similar to observations from rural Mexico. A relationship was found between social support and self-reported adherence. This provides the first quantitative validation of a qualitative report by Lipton and is consistent with studies of Caucasians. In this sample, income and diabetes control were surprisingly low, suggesting that poverty and lack of resources may be the most important determinants of adherence.

Sarah N. Carranza
Samuel LeBaron, MD, PhD
Center for Education in Family and Community Medicine
Stanford University

Acknowledgments: The Stanford Center of Excellence and the Stanford Medical Scholars Program financially supported this project. The authors wish to acknowledge significant suggestions and support from Ricardo Lopez, MD, and Cheri Ann Hernandez, PhD, RN, CDE.

Corresponding Author: Address correspondence to Dr LeBaron, Center for Education in Family and Community Medicine, 1215 Welch Road, Suite G, Stanford, CA 94309. 650-725-5339. Fax: 650-723-9692, slebaron@stanford.edu

References