

Balint groups and the Balint method

by John Salinsky

History

The Balint group is probably one of the earliest methods of clinical supervision to be provided for family doctors. The group and the method are named after Michael Balint, a psychoanalyst originally from Hungary. He and his wife Enid Balint started a series of seminars in London in the 1950s with the aim of helping GPs (family physicians) to reach a better understanding of what they called 'the psychological aspect' of general practice. The method consisted of case presentation followed by general discussion with the emphasis on the emotional content of the doctor-patient relationships. The seminar leaders were originally always psycho-analysts: nowadays a group may be led by a family doctor, or a mental health professional or one of each. Whatever their professional background, all leaders need training and experience in the specific Balint method.

Although Michael and Enid Balint were psychoanalysts, their aim was not to turn family doctors into psychotherapists but to help them to become more psychologically aware physicians. Learning to listen with close attention to what a patient was saying, was one of the most important skills which the early Balint group members were able to acquire - in a period when the teaching of what we now call communication skills was unknown. Michael Balint's book *The Doctor, his Patient and the Illness*¹ (1957) became a key text in the renaissance of British General Practice in the 1960s and the Balints' ideas achieved world wide recognition. However, relatively few doctors ever took part in Balint groups in the UK, and they were regarded with scepticism by the majority. In continental Europe (where talking about feelings is perhaps more acceptable) Balint groups have been considerably more widespread. The Balint group also took root in the USA but it was not until the early 1990s that the American Balint Society was formed and groups started to appear in family medicine residencies across the country.

Groups for established doctors

The original Balint group members were doctors who had already been established in practice for several years. Many were becoming aware of the importance of psychological and psychosomatic problems among their patients and were feeling frustrated at their lack of ability to help. Their interest and their neediness provided the motivation necessary to attend a 90 minute group once a week for several years. Nowadays, because of increased time pressures, there are very few such groups and an interested family doctor may have to be content with an annual weekend Balint group. But whatever the frequency, the established doctor will have plenty of problem patients to present. He may already have realised that some patients disturb him emotionally or provoke a withdrawal of empathy which impoverishes the relationship and reduces effectiveness. These 'traditional' Balint groups are more straightforward to lead because everyone understands the aims

of the group and it is easier to concentrate on the doctor-patient relationship without being distracted by other anxieties.

However, with a little modification, the Balint group can also be a very good way of supervising doctors in training. Michael Balint ran some groups for students in the 1960s and, in Germany, participation in a Balint group is part of the official medical student curriculum.² In the UK today, the chief beneficiaries of the Balint group are family medicine residents whose faculty members, like myself, have some experience and training in the method. In the UK, leader training is supervised by the British Balint Society. Our style and general approach to running groups has developed side by side with that of the American Balint Society in the last 15 years and the similarity is close. I will give a description of my own resident Balint group in action.

The Balint method and the resident

Residents don't choose to join a Balint group – those in my program and others in the UK simply find that the group session forms part of the curriculum. Most of them welcome the opportunity to talk about their own work with patients and, after a while, they begin to realise that the interpersonal and emotional aspects of the consultation are among the chief difficulties that they are experiencing in the transfer from hospital to community practice. Most of the group members are in the third and final year of their program and are attached to community teaching practices full time (no hospital work). The others, in the first and second years are doing their hospital rotations.

The setting: structure of the groups

The Balint sessions take place in the Postgraduate Center in the second half of our weekly half-day teaching. Because we have a total attendance of about 18 residents, we divide into two groups for the Balint session. I lead one group and my colleague leads the other. Membership in each group remains fixed as far as possible so that group members can get used to working together and get to know each other better. Some residents are with us for only a year, but others are in the program for three years. In many ways it is better to have two leaders in each group so that they can complement each other and share the responsibility. Sometimes this is possible when we have enough Balint trained faculty members. However, we feel that it is more important for the groups not to get too big as this may make it difficult for people to talk freely about their work and themselves.

Ground rules

At the beginning of a year, we give a brief explanation of the purpose and aims of the group. We usually say that it will be an opportunity for the residents to present and discuss patients who are of particular concern. These may be difficult or puzzling patients, or those who make the doctor feel uncomfortable. We are also interested in patients the doctor likes and is worried about but is not sure how to help. We say that the focus of discussion will be on what is happening in the doctor patient relationship. We say that, in our experience, understanding the patient as a person is much the most difficult part of family practice. The residents may not agree with this, especially in the early stages when they are more anxious about missing a physical diagnosis. We say that we are less concerned with finding solutions (though these will certainly be discussed) than with exploring and understanding what is going on. This should be acceptable as a restatement of advice always to reach a diagnosis before treatment. We are very interested in follow up reports because hearing what happened in the next consultation is an excellent way of finding out whether the previous discussion was helpful to the presenting doctor.

Finally we suggest a few ground rules:

- 1) Everything said in the group will be treated as confidential whether it is about patients, colleagues or group members themselves.
- 2) Everyone should be listened to and everyone's contribution should be respected.
- 3) Although people can talk about their personal history if it seems relevant, there will be no unwelcome and intrusive questioning of group members about their own personal qualities or their childhood experiences or losses.

Responsibilities of the group leader

The leader has to make sure that the ground rules, once agreed, are respected. He is responsible for starting and finishing the session on time. The available time is usually one hour and this usually accommodates two presentations. One of these may be a follow up from a previous discussion. During the session the leader needs to monitor how everyone in the group seems to be getting on. He may catch sight of someone trying unsuccessfully to get a word in – and will make a space for him. Alternatively, some one else may be talking too much and may need to be gently reminded that, while it's good to talk, it's also good to listen. As with any kind of small group work, it is vital for the members to feel that the group is a safe place in which to talk about how they feel, and how they have performed, without being jumped on or ridiculed.

One leader or two?

In this account I am describing a group with only one leader. However, when possible, I much prefer to work with a partner! The advantages are:

1. Someone to discuss the group with afterwards.
2. Someone to notice things you have missed. Group interactions can move very fast. One leader may hear something that the other has missed and pick it up.
3. Someone from another discipline who looks at the group process in a slightly different way
4. Leaders can support each other in various ways. If one gets too much involved in the case, the other can rescue him, or keep an eye on the group while he is busy.

The work of the group

I will try to give an idea of what happens in one of my Balint group sessions and of my observations and interventions as group leader. (At the time, I was working on my own). This will be followed by an example of a typical case we have discussed.

The presentation

When everyone is settled I ask: 'who has a patient they would like to talk about?' I also remind the group that we are interested in follow up consultations. There may be a long pause before someone speaks. In the early stages, people are nervous about presenting their work. I don't nominate anyone to bring a case the next week, so the presentations are spontaneous and delivered without notes. If there is more than one offer, we decide by mutual agreement who will go first. 'Urgent' i.e. very distressing cases have priority.

The first presenting doctor then tells us about her patient. (The majority of our residents are now women). She is allowed to speak without interruption until she has finished. I try to listen with as much concentration and encouragement as possible, and hope that this will provide a model of 'how to listen' for everyone else, should they need it.

During the presentation I observe the mood, the tone of voice and the body language of the narrator to get an idea of how talking about her patient is affecting her emotionally. Some presentations are delivered in a low voice with downcast eyes: others are full of animation and include direct quotation of the patient's words or gestures. Some express the doctor's anxiety and feeling of helplessness. All these emotions are easily caught by the group members who begin to experience them too.

What kind of stories do we hear in these presentations? Typical problems include:

- The patient with chronic, medically unexplained symptoms or psychosomatic symptoms.

- Patients who make what seem to be inappropriate demands: for prescriptions, certificates, letters, and referrals to specialists or for expensive investigations such as MRI scans.
- Patients who are rude or sarcastic, especially those who point out the resident's extreme youth and lack of experience.
- Patients who make the doctor feel confused.
- Family conflicts: adolescent and marital problems
- Difficulties in understanding someone from another culture
- Worryingly depressed patients who hint at suicide.
- Patients who just might have a serious physical disorder in spite of their bad behaviour.

The phase of inquiry

When the presenting doctor has finished, I thank her and ask if anyone has any questions about matters of fact which might have been missing or gone unheard. Such questions might be: how old is he? What does she look like? Does she have a partner? I explain that a Balint group works better if the presenter is spared questions at this stage about her own feelings with regard to the patient or why she did certain things - or what she intends to do next. I want to avoid a situation in which the presenter is being bombarded with questions of this kind. This may seem strange to those who are more used to a different style of supervision, but there is a reason for it. Too much questioning of the presenter prevents the other group members from exploring and reflecting on their own thoughts about the story they have heard and the feelings it has induced in them. They need to wonder, to themselves and out loud, how the patient is feeling, what she really wants from the doctor, how they would feel if they were in the doctor's shoes.

The 'push back' phase

In order to avoid interrogation of the presenter I will often ask for an end to questions after a few minutes or when they cease to be purely factual. I will then ask the presenter to move his or her chair back a few symbolic inches and then, while continuing to listen, to take no further active part in the discussion for about 20 minutes. This is called the 'push back' phase. During this time group members are asked not to direct questions or statements specifically to the presenter. The group members soon get the idea of this game and are usually happy to go along with it. They are now free to get to work on the case themselves using their experience, their imagination and, most importantly, their own emotional reactions. After an appropriate time (usually about 20 minutes) the presenter is invited to rejoin the group and share her thoughts.

To begin with, the discussion is often quite medical. The group may try to reach a physical or psychiatric diagnosis. They may suggest referral to a specialist physician or to a counsellor or social worker. If the patient is making worrying demands on the presenter the group may try to protect her by recommending strict limits on prescribing, issuing of certificates or frequency of consultation. There may

be a tendency to generalise away from the presented patient onto the difficulties which residents have in common: such as insufficient time, pressure to see too many patients, inexperience or vulnerability. Group members may introduce similar patients of their own so that the original patient is abandoned. In this situation, as group leader I have to decide how long to let the discussion go on in this way before intervening. I want to let everyone have their say and express their concerns. But I also need, sooner or later, to bring the focus back to 'the patient as a person' and the emotional interaction between one doctor and one patient. Otherwise, although the discussion may be fruitful, the specific benefits of the Balint process will be lost.

The group leader's interventions

If the group is concentrating on the doctor patient relationship the leader may need to do very little. He monitors the discussion and, if he feels that it is drifting off course, he applies a gentle touch to the tiller in order to bring it back. Interventions are often in the form of open questions, addressed to the group as a whole rather than to individuals. The question can be turned into a statement such as: 'I wonder how the patient was feeling at the end of that consultation...' The leader might also ask (or wonder) how group members are feeling about the patient: do they like her, feel sorry for, feel angry with her or feel indifferent? What does the patient want from this doctor? What sort of doctor does he want her to be? It is customary to avoid technical terms such as 'projection' or 'transference'. But the aim is to encourage the group members to be aware of their own feelings and to experience some empathy. This may not be easy to begin with as the group members need to feel safe enough to lower the defences which have so far protected them from 'emotional involvement' with their patients. And indeed, sharing and feeling some of the pain of a distressed patient can be quite bruising.

If the emotional engagement with a single patient is too uncomfortable, the group may try to head for calmer waters. The presenter may be reassured by a generalisation ('patients with a personality disorder are untreatable; there is nothing you can do'). She may be advised to refer the patient to a specialist agency and minimise her own involvement. The leader might then intervene to say that specialist advice would indeed be helpful, but the patient will continue to need a family doctor and the role of the group is to try to understand what is going on in the current doctor-patient relationship.

If the group is really in danger of forgetting the existence of the presented patient, the leader may bring her back into the discussion by representing her; he might say: 'If I were that patient I would be feeling very lost and abandoned: I would feel there was nobody to take care of me...'. This sort of intervention can be quite a powerful reviver of the group's willingness to experience feelings.

In general, leader interventions have the aim of encouraging the group to stay with their feelings and to risk a little empathy with the patient. The leader will invite speculation about and reflection on the patient's relationships and her inner world. He will try to help them, by example, to tolerate uncertainty, ambiguity and periods of silence.

How does a Balint session end?

Because we are not seeking solutions, the end is often inconclusive. The leader will not as a rule, summarise the discussion or make any statement about what has been achieved. He will not make any recommendations for further management of this or any similar case. He will usually thank the presenter for providing the case and ask her to give a follow up report when she feels ready to do so.

An example of a case

Presentation. Lucy (a resident) presented a young woman of 27 (Yvette) whose records showed she was always turning up 'inappropriately' at the doctor's office for Saturday morning emergency clinics. The patient had an extensive skin rash whose management was difficult. Her usual doctor was waiting for advice from the hospital clinic about a change of treatment, but the patient had failed her latest appointment. The patient was quite reluctant to reveal the full extent of her rash. Lucy did her best to examine her and explained the situation. Then she decided she must educate her about not coming on Saturdays because there was not enough time in an emergency slot to deal with her complicated problem. Yvette said: 'you doctors are all the same' and called Lucy 'a discompassionate bitch.' Lucy was shocked and hurt but didn't retaliate. She continued the consultation and spent about half an hour with the patient altogether. She tried to explain that a weekday consultation would be more helpful: but everything she said to Yvette went 'in one ear and out of the other'. She asked her when she left to make a double appointment on a weekday in five weeks' time: but she didn't. Lucy finished by asking how other people would deal with the problem.

Discussion. After expressing sympathy for Lucy's bad experience, the group immediately moved to the general problem of how to educate or discipline patients not to come on Saturdays with ongoing problems that needed regular review.

I let this go on until my discomfort was too great. I wanted to get the group back on the Balint track of looking at the individual doctor-patient relationship. *I reminded them that this was the main purpose of the group and said I thought that we might learn more about the general problem also if we tried to understand Lucy's patient, Yvette, better. Why did they think she had behaved in this outrageous way? What sort of person was she?* Lucy said she worked in the financial district as a Personal Assistant. Someone said that she probably had a very stressful job and was treated very badly and 'discompassionately' at work. Other people said that Yvette was completely self-centred and didn't care a damn

about other people's feelings. She wanted to make Lucy feel bad and she had succeeded. Someone asked if she had a relationship and when Lucy said she was single, people smiled and said they weren't surprised. Lucy said that Yvette had behaved like a child and someone else said it was like a tantrum. There was some brief speculation about whether she had had an unhappy childhood. *I asked how people thought she had felt on leaving the office.* Someone said she might have felt some remorse but others thought this was unlikely. The dread phrase: 'personality disorder' was mentioned. There was general agreement that Yvette was a very unhappy person, ashamed and humiliated about her unsightly skin. Perhaps she was jealous of Lucy who was clearly a successful professional woman of about the same age with no skin problems. *I asked if the fact that she was unhappy made the group feel any more liking and concern for her.* There was cautious endorsement of this idea. But how can you help someone who is so negative and deliberately messes things up?

I asked 'What sort of help does she really need; what would you do if she was your sister?' One of the women said: 'give her a good slap on the face!' After some laughter, there were more serious comments about her needing some love and attention but it would be very difficult to provide because she seemed to relieve her feelings by trying to hurt or annoy people. Lucy remembered that, as she left, Yvette gave her a cheeky grimace as if to say 'so there!' After this I said little because the group seemed to be more focused, concentrating on the relationship and not being side tracked. At the end Lucy said she would be quite prepared to see the patient again and was not frightened of her. She promised to provide a follow up if there was another consultation.

How might the Balint group help? Objectives and hopes

As a result of regular participation in a series of Balint groups, I would hope that the residents would:

- Feel listened to, supported and understood when they present cases
- Become more tolerant of 'difficult' patients
- Be more empathic to patients' feelings including negative ones.
- Become more aware of their own feelings in the consultation and be able to use them in reaching a diagnosis
- Allow their natural curiosity about patients as people to emerge
- Gain some insight into why they find some patients particularly difficult or disturbing.

How far are these expectations realised? I asked the residents to give me their impressions of how they experienced the Balint sessions and audio recorded the discussion for about 20 minutes. This is a summary of the themes that emerged with some quotations to illustrate them:

1. Overcoming isolation. It's good to get other people's opinions...how they would deal with it. After hospital, you feel very isolated in a community

- practice. No one else sees the patient. It's scary. Good to talk with your peer group. Everyone feels exactly the same – it's a real confidence builder.
2. Clinical uncertainty. My first worry was: how do I cope clinically. How many people will die because I've missed the diagnosis?
 3. Doctor patient relationship. Realised how important it is. What do people come for? Not just about clinical problems. We need to know more about how they developed. Important to keep an open mind.
 4. Group leaders' role. You want to steer us away from the medical side towards the psychological. To look at what's behind...
 5. See patient as a human being. I am much more patient centred now. The group helped me with that. It reminds you what family medicine is all about. Hospital medicine is all about 'they – they –they'. We try to remember there is a human being sitting there. Not coming to attack you, coming for help. I feel more sympathetic towards them. It seems muddled but there's always a good reason why the patient has come.
 6. Dealing with fears of being thought inadequate. Do they know who we (residents) are? They just know we are young. Often they really wanted to see one of the partners, the doctor they know.

Does Balint have a lasting effect in creating 'a culture of supervision'?

Doctors who have taken part in Balint groups may be divided into

1. Those who had a brief exposure, didn't much like it and have no further use for it.
2. Those who were in a group for a year or more, never returned to it, but still regard it as a positive experience.
3. Those who continued to be interested, joined a Balint Society (in the UK or elsewhere) and continued to participate in groups when possible throughout their careers, either as members or group leaders or both.

Sadly there is no satisfactory quantitative data on the first two groups. Those in group one may have been in an inadequately led group or may simply have been temperamentally unsuited to this form of supervision. The evidence about group two is so far only anecdotal. Nevertheless, leading members of the profession have publicly acknowledged the lasting benefits of their youthful experience in a Balint group.^{3,4}

The third group, the Balint Society members, self evidently continue to see Balint work as an important part of continuing professional development. There are at present few opportunities in the UK for established doctors to join ongoing groups. Enthusiasts have to be content with weekend groups such as The Balint Society's annual Oxford meeting. In France and Belgium, Balint groups are much more widespread and in Germany, where the Balint Society has over 1000

members, the method has become a recognised part of the curriculum of training and supervision for students, trainee family doctors (and psychiatrists) and mature family doctors. In the USA while enthusiasm for resident Balint training is spreading, there are, at present, few opportunities for established community doctors to join an ongoing group.

Research on the effectiveness of Balint groups

In the last few years we have seen the beginnings of a serious attempt to evaluate the effectiveness of Balint groups by looking for evidence of a change in attitudes and values in those who have experienced the process. Work is also being done on comparing the development of groups of doctors who have experienced Balint training with those who have not. The early stages of some of these projects were described in the International Balint Congresses in Oxford, England (1998)⁵, Portoroz, Slovenia (2001).⁶ and Berlin, Germany (2003) Both quantitative and qualitative methods are being used. Preliminary results suggest that young family doctors who are Balint trained are more psychologically skilled⁵ more tolerant of patients whose diagnosis is uncertain, more reflective and more aware of their own feelings about patients⁵ They have a greater degree of job satisfaction, are more able to tolerate feelings of helplessness and are less likely to suffer from 'burnout' (Mandel et al, Israel)⁶ They have a more holistic approach, a more positive attitude to psychosomatic disorders, greater work satisfaction and are less likely to refer patients or order unnecessary tests (Kjeldmand, D (Sweden).^{5,6}

In the UK we have commissioned a project in which a Balint group was studied by an independent researcher using an ethnographic approach to examine qualitatively the kind of learning that goes on.

In the next few years, these and other projects are likely to develop further and achieve publication.

Conclusions about benefits and limitations.

Taking part in a community or faculty Balint group involves time and commitment. Unless a suitable number of doctors in a locality can be found (ideally 8-10) the group will not be viable. A suitably trained and experienced leader or leaders will need to be available and everyone will need to commit to a regular meeting over a period of at least a year. Residency directors and faculty that wish to run Balint groups for residents have the advantage of a ready made group but they may be insufficiently skilled to act as Balint group leaders. Ideally, a group has two leaders, one of whom is a family doctor and the other a behavioural scientist who works with residents and is familiar with their problems. Both will need training in the Balint method through attendance at Intensive training seminars and supervision of their work, leading to credentialing. Given these difficulties does the Balint group offer enough to make the effort to start one worthwhile?

Other forms of supervision for GPs may provide excellent evaluation and mentoring of the doctor's clinical skills, diagnostic reasoning and ability to evaluate evidence. But the important emotional component of medicine⁷, which can be painful to examine, may be avoided and glossed over. The Balint group is a unique supervision method whose chief concern is with the sensitivity of the doctor to the emotions of both doctor and patient. Hopefully, greater awareness will lead to better understanding and enable doctors to mobilise their emotional intelligence in the interests of both their patients and themselves.

John Salinsky 2003 (revised 2005)

References