PARENTING AND BALINT LEADERSHIP: RAISING EMOTIONALLY INTELLIGENT DOCTORS

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This presentation will attempt to show the similarity between parenting styles that lead to secure attachment, emotional intelligence, and positive outcome and Balint leadership techniques that produce the highest likelihood of achieving this result in a Balint group. The comparison between positive parenting and Balint leadership was stimulated by the observation that participants often feel nurtured and develop a very positive attachment to their Balint group. And, by the observation that participants describe themselves in subsequent contacts with patients that are presented in Balint group as being freer to relate to the patient in a variety of ways (just as secure attachment frees a child to explore their world). I must admit that although the parenting data is well substantiated in the literature, many, but not all, of the Balint parallels are from personal observation and discussion with other Balint leaders in the U.S.A. This discussion is also motivated by my attempt to explain why working in, and making connections in the Balint community feels so engaging, growth promoting, and just plain good.

At the foundation of parenting and Balint leadership are basic assumptions on which the rest of both enterprises are based. First, there is the assumption that the human beings have inherent value. Human value does not have to be proven instrumentally. In parenting, as far as is possible, one does not love conditionally. In Balint work a group member does not have to prove competence. Balint work is built on the assumption that everyone in the group is competent in their profession. If there are struggles in a case, it is because the relationship between doctor and patient has yet to be examined. This assumption is in fact played out when the presenter gives the case to the group and the group then owns both sides of the relationship struggle. Perhaps in no other place in medical education is one fully accepted as competent for level of training. How nice not to have to prove oneself – either to one's parent or to one's Balint group leader.

A second assumption that both secure attachment parenting and Balint leadership share has been referred to as Mind-minded parenting (1) "Parents who are "mind-minded" treat their children as individuals with their own minds. In essence mind-minded parents see their children as separate human beings with a right to feelings and thoughts. The same holds true in Balint groups. Balint leaders may suggest that participants use I statements to keep respect for each individual at the forefront. Interventions may be prompted when there is criticism or when there are statements that presume how the presenter feels, or what the presenter is thinking. These interventions serve to emphasize the importance of respect for all group members' boundaries.

A third assumption is that individuals' rate of development and differentiation of different affect areas vary based on temperament and experience. Thus, some people can recognize and manage anger but not sadness or dependency. It might be the other way around for someone else. The point both in secure attachment parenting and in Balint leadership is to help the individual, or perhaps the group in Balint, to go

through the process necessary to broaden one's abilities for self awareness in multiple areas of affect. Having blind spots is a natural consequence of being human; this becomes an opportunity for learning rather than being experienced as a failing in competence.

The assumptions outlined above hopefully provide the secure base from which children, in regard to parenting, or doctors in regard to Balint can venture into new territory. According to Borell-Carrio and Epstein one of the cognitive errors that doctors make is to shut down the decision making process too soon (2). Not knowing in terms of diagnosis and confusion in terms of how to manage particular areas of affect are both anxiety provoking. A natural reaction is to retreat into premature closure with diagnosis or shut down a conversation. A secure base in a Balint group, especially after the discussion of a case, hopefully allows the doctor to better tolerate the anxiety and venture out with a bit more understanding into new territory.

In the broad sense, as we build on the assumptions above, it would be instructive to look at parenting styles as they impact a child's outcome via secure attachment, and their implications for Balint leadership. Diana Baumrind's studies delineated a typology of parenting styles based on levels of control and responsiveness; authoritarian, authoritative, permissive indulgent, and uninvolved (3). Authoritative parenting is both responsive to the needs of children and exerts control based on reasoning and explanation. Authoritarian parenting is more apt to use power to exert discipline without a great deal of explanation. Permissive parenting has relatively high levels of responsiveness and warmth but low levels of control. Uninvolved parenting has both low levels of responsiveness and control. There is a great deal of data to suggest that authoritative parenting is related to the highest level of positive outcome in social, academic and behavioral spheres (4,5).

How does one translate authoritative parenting into Balint Leadership? The clearest way is to view leadership through the dimensions of support and control. Outcome data indicate that support has a linear relationship with outcome for social, academic, and behavioral success, whereas, control has a curvilinear relationship (6). That is one can't have too much developmentally appropriate support in parenting. However, a moderate level of control works out best. These are the defining characteristics of authoritative parenting (3). Johnson and his colleagues reached the same conclusions in their study of essential characteristics of effective Balint group leadership (7).

How does maximum support and moderate control translate into Balint leadership? As for support, it is important to be clearly respectful and supportive both verbally and nonverbally. Warm presence, positive regard, and a willingness to listen, validation of thoughts and feelings, an occasional willingness to voice one's own feeling state, and an appreciation of the struggles inherent in the doctor patient relationship are all possible ways that a leader can shows support. As for control, Balint leaders exercise control by enforcing boundaries and the rules of the process. Enforcement is done with developmentally appropriate explanation – early groups would get more explanation – as in authoritative parenting. The Balint group structure provides the security necessary to do the work. Lax structure with poor boundaries (permissive parenting or uninvolved parenting) or rigid structure with no explanation or regard for context (authoritarian parenting) are apt to lead to suboptimal results. As Balint et al state "The seminar

provides a stable setting to explore the vocabulary of the doctor's feelings within the framework of his relationship with his patient."(8)

The elements of authoritative parenting, support and control, provide a basic structure to understand the container of a secure environment. However, a more precise understanding of how authoritative parenting and Balint leadership can help develop the ability to represent and integrate the gamut of affect states is even more useful. For that purpose I would like to revisit the suggestion that Frank Dornfest and I made at the Congress in 1998 to use Greenspan's model of ego development to understand how change takes place in Balint groups (9). Greenspan proposed that "Intellectual activity requires affectively mediated creation of personal experience and the logical analysis of these experiences" (10). For what we might now call emotional intelligence a person has to be able to remain reasonably calm, stay connected and focused in interpersonal exchange, with an awareness of the emotional state of oneself and the others involved. According to Greenspan a child goes through stages of ego development in order to be able to perform those functions. The stages might be demonstrated in a doctor patient interaction as follows:

> The first stage in the model is **Self Regulation**. The doctor has to be able to handle an interaction at the basic level of maintaining equilibrium while processing stimulation. If the doctor becomes overloaded, then at that point cognitive processing will stop. (If a doctor has a family in a room and everyone is talking at once there is very little cognitive processing that takes place. A doctor who can self regulate would be better able to maintain calmness even in this chaotic atmosphere.)
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> The second stage is **Engagement**. This is the ability to develop and maintain emotional connection. (If the family hates doctors and says so verbally and nonverbally it is very difficult to develop and maintain an emotional connection. A doctor who is able to engage in the face of anger will be able to stay connected.)
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> The third stage can be described as **Intentionality**. That is the ability to maintain purposeful and organized behavior through a range of different emotions. (The doctor may be able to remain relatively calm and to feel some compassion for the family we are talking about. However, he may not be able to direct the session very well because he loses his train of thought when patients are angry at him. Someone functioning well in this stage would still find ways of directing the session.)
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> The forth stage of development is **Synchrony**. Synchrony is the ability to read accurately and respond appropriately to emotional cues. (The doctor may read the family as just being angry when there are cues that would also indicate that they are anxious and frightened. A doctor functioning synchronously would read and be able to respond to all emotions that are present.)

The fifth stage of development is **Verbal Representation**. Verbal representation is the ability to translate the full range of emotions into words and ideas. (The doctor may instinctively respond to the family's anger and to their fears. However, he might not be able to put his own emotions into words that he can consider before acting them out. That is, he might act out his anger or compassion without considering which makes sense in the particular context. On the other hand, a doctor functioning well at this stage would be able to represent his emotions in words and act in a well thought out way.)

The sixth and last stage of development is **Integration and Synthesis**. Someone functioning well at this stage would be able to extract patterns, make new connections, and generate abstractions to organize new behavior patterns in the future. (The doctor struggling with this stage may be able to verbalize that the family made him angry; however, he would have difficulty generalizing from this experience and using the generalization to change the way he acts. Someone who has mastered the last stage of development might understand that he reacts to anger with anger of his own. He would then decide whether this makes sense and if not consciously try to make changes and not react back with anger. (9)

Balint et al. likened a doctor to a participant observer as both a data gatherer and treatment provider (8). When there are areas of poorly differentiated affect on the part of the doctor there is a chance of "observer-error" with miscommunication and lack of clarity. The learning point in the group is to help the presenter, and perhaps other group members to develop an understanding of the (cognitive/emotional issues) represented by the case. According to Greenspan, it may well be that someone is not necessarily defending against experiencing a painful emotion; rather, it may be that the person hasn't developed the capacity to represent or reflect on particular affects and acts out behaviorally instead. This may be due to the family of origin's parenting or to wider cultural prohibition. When viewed in this framework, we would consider that the presenter presents a case because they are stuck somewhere in the developmental process outlined above. The group would process the case until it too is stuck in a particular stage. The leader would then intervene at the level the group can manage and perhaps nudge the group along a bit. In essence this could be thought of as parenting a group in order to be able to master a difficult affective area. This process is akin to techniques suggested by Haim Ginnott, and later by Elias et al that help children calm down, think through, and define upset rather than acting it out (11,12). Hopefully this leads to a sense of mastery and competence.

Balint leaders' interventions attached to the various stages might be as follows:

1. Self (or group regulation) – Maintaining a calm presence
   Maintaining a reasonably conducive area for group process
   Maintaining group rules such as one person speaking at a time,
   Minimizing interference from outside source – e.g. beepers
   Being aware of intense emotion from non-group events

2. Engagement – Monitoring emotional connection of the group members

All sorts of nonverbal acknowledgement and connection with group members by the leader

3. Intentionality – Maintaining a sense of oneself in the leadership role
   Monitoring the flow of the group process in regard to dynamics, issues and affect in the case and in the group
   Monitoring communication loops between group members and the group and the leader
   (similar to leading an orchestra where the parts and finale are only partially defined)

4. Synchrony – Matching leadership moves to group needs and level
   Knowing when a group is moving and not getting in the way
   Knowing when a group is stuck and doing something
   Matching pace of intervention to the pace of the group
   Synchrony with the case – blocking harmful parallel process

5. Verbal representation
   a. On a behavioral enactment level
      What did the patient look like?
      What would the patient say if they were here?
      What is our inclination to do when the patient did…?
         What would it be like to be in that situation for the doctor – for the patient?
   b. Moving from behavioral to increasingly abstracted/defined verbal representation of the feeling state (e. g., From: " I would feel tense, awful, heart sink patient," to: " disappointed, guilty, incredibly angry, sad, remorse")
      What does this situation bring out in thought or feeling for the doctor?
      Helping the group to validate and further define the possible feeling states
      Acknowledging the feeling in oneself

6. Integration and synthesis
   Helping the group to elucidate systems issues and how they impact the relationship
   Noticing how the group works through different presentations of the same type of patient situation
   Judicious use of summary, teaching (particularly in training groups)

In summary Balint leadership and parenting for secure attachment have a great deal in common that optimally have the capacity to promote a safe, growth oriented environment. Techniques that define authoritative parenting help to inform Balint leadership. In particular Greenspan's framework of ego development can help define how

Balint leadership moves promote verbal representation and integration of affective states so that instead of acting those out behaviorally doctors will have the self and other awareness that promotes the best relationships with their patients (see figure 1. one case example).

In the future one might research this area by tracking cases presented to see whether working through a particular affective area produces higher levels of integration and changes in behavior. Follow ups where group members have tried new ways of relating are another possibility. It might also be interesting to survey Balint leaders to see whether the assumptions I outlined at the beginning of the presentation are universally held.

If indeed Balint leaders function parallel to authoritative parents, they very likely promote a sense of valuing each group member, protect individual boundaries, and help the group move toward growth. This allows and supports the group to focus on the elements of the doctor patient relationship rather than the lack of competence of the presenter. It is no wonder it feels good to be part of such an undertaking.

References:

1. Dewar, Gwen. (2009) Mind-minded parenting: How mental state talk helps kids learn about beliefs, feelings, and the perspectives of other people. Website: http://www.parentingscience.com/mind-minded-parenting.html

2. Borrell-Carrio F, Epstein RM. Preventing errors in clinical practice: a call for self-awareness. Ann Fam Med 2004;2:310–6.

3. Olson, D.H, Defrain, J, Skogrand, L.(2011) Marriages and Families: Intimacy, Diversity, and Strengths. New York: McGraw-Hill.

4. Nurse, R.A. A 60-year study of normals through time: Implications for practice. The Family Psychologist, Spring 2004; 35-38.

5. Avenevoli,S., Sessa, F.M. and Steinberg, L. (1999). Family structure, parenting practices, and adolescent adjustment. In E.M. Hetherington (Ed.), Coping with divorce, single parenting and remarriage (pp65-90). Mahwah, N.J.: Erlbaum.

6. Amato, P.R., and Booth, A. (1997) A generation at risk: Growing up in an era of family upheaval. Cambridge, MA: Havard University Press.

7. Johnson AH, Nease DE Jr, Milberg LC, Addison RB. Essential characteristics of effective Balint group leadership. Fam Med 2004;36:253–9.

8. Balint, E. Courtenay, M., Elder, A., Hull, S., and Julian, P. (1993) The doctor, the patient, and the group: Balint revisited. London: Rutledge.

9. Lichtenstein, A.B., Dornfest, F., Riesenberg, L. (1999) Understanding Change in Balint Groups. In John Salinsky (ed).Proceedings of the Eleventh International Balint Congress 1998 (pp 113-116). Southport, England: Limited Edition Press.

10. Greenspan, S.I. (1997) Developmentally based psychotherapy. Madison, WI: International Universities Press, Inc.

11. Ginott, H.G. (1969) Between parent and child. New York: Avon Books.

12. Elias, M.J., Tobias, S.E. and Friedlander, B.S. (1999) Emotionally intelligent parenting: How to raise a self-disciplined, responsible, socially skilled child. New York: Three Rivers Press.

Figure 1.

	Case example	
	Parenting	**Balint presentation**
	10 yr old boy runs into the house after losing a basketball game. Throws his dirty closes on the living room floor knocking over a table with his brother's puzzle. He goes into his bedroom.	…… presented a patient who she inherited from ..... He is diabetic, and chronic pain, had been on Vicodin and 30mg of Valium QD. His wife had left him and he was with a 17 yr old daughter who was acting out. She confronted him about the drug use and he agreed to get off the pain meds. She was struggling with feeling bad about confronting him and taking away the meds. He was active in taking care of his daughter, though he wasn't working, and also coming to sessions with her every 3 months regularly. The daughter had stayed with him when he split with his wife.
Stage of ego development	**Parenting intervention**	**Leadership intervention**
1. Self Regulation	Gives the boy time to calm down	Group settles in, early morning meeting
2. Engagement	Knocks on the door, walks in, and sits down on the bed	Chit chat with group Maintain emotional availability
3. Intentionality	Keeping calm, noticing the boys emotional state	Make sure door is closed, call the group to order Ask for a case Calm listening to negative description of "those kinds of patients"
4. Synchrony	Waits for the boy to look up	Wait for case to be presented Prompt if not
5. Verbal Representation	"Looks like you were pretty upset. What happened? " "How did that make you feel?" Further help defining and elaborating emotion.	Group initially verbalizing anger "We have a number pts who are on narcotics and out of work - why present this patient?" "Like the patient - he takes care of his daughter – I took away the meds - he is in pain" "What is it like to be this patient?" Group responds with - pain - go on to define the pain as both physical and emotional. Further work towards a sense of hopelessness in helping the patient
6. Integration and synthesis (example of authoritative parenting)	"I can understand your upset but I bet your brother is upset too now that his puzzle is trashed." "Please go pick up your clothes and the puzzle pieces." " How do you want to handle your brother's upset/"	Clarity about difficulty in working with drug dependent pts in difficult emotional situations. "Do the narcotics get in the way of being there for the patient?"