

BRIEF REVIEW OF LEADERSHIP FUNCTIONS AND ISSUES

From: BALINT LEADERSHIP WORKSHOP

WesternSTFM
San Diego - October 19, 1991
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OVERALL LEADERSHIP ROLE:

The leader, although designated, uses a shared leadership style to address both task and group maintenance. This means concurrently:

Recognizing the expertise and contributions which other group members bring from their clinical and general life experience; while taking by consent, responsibility for the tasks of:

- setting the frame for the group
- helping the group to continue on its vector through the material arising during case discussion.

The vector is directed toward increasing sensitivity to what occurs - both consciously and unconsciously - in the minds of the doctor and patient when they are together. Pursuit of this goal involves repeatedly re-focusing the group's energies towards this task by bringing a special set of skills to the group.

At the same time the designated leader shares with the other members the maintenance roles required to create an atmosphere supportive of the individuals during their exploration, constructive debate and critique of the doctor-patient relationship.

OVERALL GOAL FOR GROUP MEMBERS:

To develop a biphasic affective skill. The first phase is to identify with the patient. In the process, members learn to set aside their own intruding perceptions and emotional reactions at the root of their habitual responses or blind spots. The initial emotions and perceptions are conscious. Later, the group members begin to deal with notions, perceptions and emotions which were unconscious and begin to become available for examination. The second phase in learning to separate again after identifying with the patient. This is necessary in order to be freed up to evaluate the potential array of options for the patient.

TASK-ORIENTED ROLE:

- Setting the frame

Overall - to create an atmosphere which is free and friendly in which the group member can experiment and discover amongst other things that his/her behavior is often quite different from that intended. Of course, behavior speaks much louder than words. This is not easy or comfortable to begin to see one's mistakes, distortions, blind spots and limitations - so the group, with the leader has to work on sufficient cohesion to support this process and allow each other to make these discoveries at a comfortable rate and in an understanding and accepting atmosphere. The atmosphere is one how everyone doing this work has blind spots thus must allow the same understanding of the leader's fallibility.

Details:

No notes, group frequency and duration, limit personal revelation - personal V's professional ego, ask themselves questions rather than ask others.

- Model listening.
- Hold back until everyone had a chance to get involved.
- Model tolerating uncertainty. If you are not confused you will not be able to understand.
- Maintaining the focus.
- Occasional comments on group process that is interfering with group process but almost never group interpretations.
- Representing the patient's feelings - if no one else does.
- Model tolerating silence, sadness, anger, being stuck.
- Resist temptation to treat the presented patient.
- Legitimizing the use of common sense rather than medical, psychiatric or psychological knowledge.

GROUP MAINTENANCE ROLE:

- Maintaining the frame.

Punctuality, confidentiality, protecting the presenter and members by reflecting questions, avoiding distractions, consulting about visitors and new members.

- Avoiding most group interpretations.
- Model "don't just do something - stand there."
- Encouraging playful speculating.
- Encouraging by being warm, friendly and responsive.
- Expressing group feelings - sensing feelings, moods, and relationships within the group - sharing with them from time to time.
- Harmonizing - reconciling disagreements and getting people to explore their differences.
- Compromising - admitting error, offering to compromise one's own position.
- Gate-keeping - facilitating the participation of others.
- Avoid relationship issues outside the professional domain.
- Shared observing of data about the group life to better understand overall direction. (With residents, helping to foster a group feeling of identity in a constantly changing group.)

SPECIAL SKILLS:

Recognize effects on one's own need to succeed and have group succeed. Trying too hard as in tennis and golf.

Active passivity (motor passivity) tuning a third ear into what is going on in group, kind of case presented; reaction of members to case, the presenter, leader and each other; do certain members behave in a certain way and what does that mean; listened to what is not said and why.

Make a quick diagnosis of the patient then not treat the patient but use the diagnosis to inform his work group. Will miss things in process but will allow leader to decide what it's like for members learn from the presentation.

Recognize Group Crisis. Especially the group singling out an individual/an individual isolating themselves - usually out of step with the group. Thus lacking the group's support to tolerate insight about the gulf that separates them.

Understand the time scale on which the group deals with issues. Understand the timing required for individuals or the group to deal with issues by allowing members to discover by making mistakes through habitual responses and seeing how others deal with the same situation better.

Recognition of parallel process. Understand parallel process and be able to use the understanding to e.g. model in the here and now of the group, by their own tolerance of group member's errors, how to tolerate listening to their own patients' errors and distortions and allowing them to be themselves.

Allowing group members to be prima donnas or devil's advocates.

Exposing collusive avoidance of the leader's errors and shortcomings. The group should be able to critique the leader and have some fun at his expense without rejecting him or being hostile.

Recognize manifestations of resistance: avoidance, denial, over-dependence on the leader, flight-fighting, isolation.

Recognize the stages of group development (Clive Brock):

This is a much more useful description of the developmental steps of the group than classical "forming, norming, storming, reforming and adjourning."

Phase 1: Exploring boundaries: omnipotence (helping everyone or no-one and identifying idealized expectations). The group presents ("pregnant nuns") demanding patients, patients who have quit on hope - narcotics, helplessness and non-compliance. Ends in appropriate humility and acknowledging professional role responsibilities and limitations.

Phase 2: Intra-Group intimacy: This is a springboard for examining personal specific blind spot areas. It requires increased group trust in presenting taboos like sex, money and where these interfere with patient care. The phase ends with dealing with loss, including the loss of the group. Hopefully, ends with clear understanding of how patient issues precipitate doctor's conflicts and being able more easily to disentangle their own issues from the patient's.

Recognize significant communications.

Skill at clarifying, summarizing, initiating or suggesting.

Direction, tolerating uncertainty, silence, disagreement.

Opinion seeking; consensus-checking.