Brief Reports

Gearing Balint Group Leadership to Resident Professional Development

Clive D. Brock, MD

ABSTRACT

This paper discusses the sequential phases of typical Balint training groups. The cases presented reflect the presenters' professional developmental time line and serve the participants' developmental needs: exploring professional boundaries and intragroup intimacy. The activities and issues arising in the meetings stem from these developmental needs and help the group members acquire specific skills. Knowing where the group members are in their professional development should help group leaders give a seminar its focus, decide on group membership, and recognize when a group is not developing appropriately.

(Fam Med 1990; 22:320-1)

In the Balint group training format[1-4]--seminars designed to study specific doctor-patient relationships --several content and process issues have been observed that will help group leaders. A Balint group passes through two phases (Table 1) over a two-year period of training. These phases are not discrete, but are highly interdependent. Each phase has its own developmental task (purpose). In Phase I, the group task is to explore the professional boundaries (expectations) of a family physician; group members struggle with the issues of omnipotence and omniscience versus realistic role expectations. In Phase II, the group task is to develop and maintain an atmosphere of intragroup intimacy so that individuals can explore participant-specific professional issues. Phase II also provides the setting for leaving at the conclusion of the training. The cases presented to the group raise issues which serve the phase-specific task and mirror the participants' professional developmental time line and skills.

These observations about a Balint group's evolutionary phases resemble Ginzberg's three phases of occupational choice:[5] exploration, crystallization, and specification.

Phase I. Boundaries

Residents in beginning groups are newcomers to family practice. The cases they present explore the boundaries of their professional responsibilities. Residents present patients whose boundaries are either tightly closed to the doctor's understanding or ill-defined and demanding of all-inclusive attentiveness. These patients frequently somatize their emotions and lead lonely lives. Residents hope to learn what they can do to help these patients get better.

At the end of this phase, group members begin to acknowledge the limits of their professional responsibilities with appropriate humility in contrast to feelings of resentment and bitter disillusionment. They learn that it is not always possible to solve all their patients' problems. Instead, they realize that what is required of them is to be there for their patients. This realization sets the stage for the next phase, intragroup intimacy.

Phase II. Intragroup Intimacy

Intragroup intimacy (group cohesion) crystallizes around six to nine months into training, at a time when second-year residents are also becoming involved (intimate) with the philosophy and practice of family practice. This intimacy is derived from trust. Trust in self and in other group members[6] determines degrees of involvement and data flow within the individual member and among group members. The types of cases heralding this second phase often have to do with intimate human relationships. The cases that come next raise issues that reflect individual group member's recurring problems (blind spots) with specific patients or situations.

Toward the end of this second phase many cases presented concern patients with chronic or terminal illnesses. These cases strike a familiar chord of sadness in the participants, reminding them that their life as a group is also coming to an end.

At the end of this phase, group members should be skilled at being fully attentive to one another and to themselves, enabling them to recognize feelings that their patients generate in them and keep these separate from their own personal conflicts.

Discussion

The observation is not unexpected that issues arise in Balint group seminars dependent on a time line in phase with the resident physician's stage of professional development. How can this observation be helpful to group leaders? Consider the following three ways.

1. *Membership of the Group:* When starting a Balint group training program, the leader ideally should limit membership to residents who are at the same level of training. Group membership should be closed early. The author has noticed that mixed groups (different levels of residency training) and open groups (different levels of Balint training) will develop conflicting needs. For example, one subgroup of regularly attending participants may be reaching the phase of intragroup intimacy while other residents in the same group may be coming to the end of their resi-

From the Department of Family Medicine, Medical University of South Carolina, Charleston.

Address correspondence to Dr. Brock, Department of Family Medicine, Medical University of South Carolina, 171 Ashley Avenue, Charleston, SC 29425-5820.

Table 1

Developmental Phases of a Balint Training Group Over Two Years

	Developmental Task	*Issues Presented*	*Skills*
Phase I	To explore one's boundaries	Professional role delineation Unrealistic patient demands Helplessness Noncompliant patient behavior	Ability to identify idealized expectations
Phase I completed	To acknowledge limits of professional responsibility	Phase I completed	Appropriate humility
Phase II	To develop intragroup intimacy	Sexuality Feelings generated in MD by patient and illness Conflicts interfering with patient care Loss	Ability to trust colleagues Ability to identify realistic professional expectations
Phase II completed	To recognize feelings generated by patient and illness To separate personal conflicts from patient care	Phase II completed	Full attentiveness to colleagues and self

dency training and facing graduation. Each subgroup will have different interests, one being interested in fostering group cohesion with the other being concerned with dissolution. Open groups likewise have participants with different levels of training, skills, and needs.

2. *Choosing the Problem for Group Focus*: Another issue facing a group leader is how to choose direction when more than one problem is brought out by a case. For example, the presenter may bring up the case of a dying young person who is a member of a close-knit, caring family. The problem for the presenter may include disappointment with the limits of medical management, over-identification with the family, or loss. Knowing where the group is developmentally will determine the group focus. A starting group would be concerned with limits, a cohesive group with over-identification, and an advanced group with loss.
3. *When the Group Is Out of Phase*: There are times when the group's progress does not follow a predictable time line. The group leader needs to ask whether the group has achieved a level of cohesiveness and mutual trust sufficient to move ahead. This commonly happens between Phases I and II and toward the end of training.

Some clues surface when the group is stuck. These may include the following: a member might openly express dissatisfaction with the group's progress; the same case may be brought up a second time; no case may be forthcoming; a case may be brought up that the presenter is not struggling with; two group members might become antagonistic and distract attention from the group's reluctance to move on.

Recognizing these clues, the leader can use the clues rather than the case as the focus of the seminar.

Conclusion

A Balint group leader needs to use the same kind of clinical skills within the group as is expected of a physician in the office. In one situation, the patient provides the lead; in the Balint-group, the resident physician provides the lead. The patient's level of readiness is analogous to the resident's level of development. In this paper, the author has presented some ideas which might assist leaders to more effectively work with residents who participate in Balint groups.

Acknowledgement

The author wishes to acknowledge Dr. Alan H. Johnson for his help in preparing this manuscript.

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