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Balint groups: an Australasian perspective for psychiatrists

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Abstract

Objective: This paper aims to provide a brief overview of the history and scope of the Balint movement; to outline how Balint groups work; to describe what is entailed in leading a Balint group; and to give a brief overview of the current state of Balint work in Australia and New Zealand.

Conclusions: Balint groups provide a unique setting in which clinicians can learn how to deal well with challenging doctor–patient relationships and the feelings evoked in clinical practice. Balint work is relatively undeveloped in Australasia. There is scope for involvement by psychiatrists and trainees as both participants and facilitators.

Keywords: Balint groups, Balint in Australasia, psychiatry training, reflective practice, doctor–patient relationship

A Balint group is a small group of clinicians who meet regularly to discuss cases from their practices, with a focus on the psychological aspects of their work and particularly on the doctor–patient relationship. Balint work is relevant to psychiatrists because it can provide a unique learning experience both for psychiatry trainees (where it can nurture trainees' interest in people and what makes them 'tick')¹ as well as for practising psychiatrists, and because of psychiatrists' potential role as Balint group leaders.

This article is intended to be an introduction to Balint groups for psychiatrists and trainees who may not be familiar with them, particularly in the current Australasian context where there are very few Balint groups in either undergraduate or postgraduate training programs.

The history of Balint groups

Balint groups were named after the psychoanalysts Edith and Michael Balint, who led groups of general practitioners (GPs) at London's Tavistock Clinic, starting in the 1950s. These groups explored the psychological aspects of general practice by discussing cases from their own practices. Michael Balint's book *The Doctor, the Patient and His Illness*² describes this work and the many insights it engendered. The Balints' seminal work with GPs strongly influenced the recognition of general practice as a unique and important specialty.

The first Balint Society was formed in the UK in 1969 and the International Balint Federation in 1972.³ Balint groups have developed in many countries, including

many European countries, Israel, the USA and China. Nowadays, Balint groups are used mainly for medical students,⁴ for medical postgraduate trainees especially in general practice and psychiatry, and for practising GPs.⁵ Since 2010, psychiatry training in the UK has mandated about a year's experience in weekly case-based discussion groups which are generally run as Balint groups (pers. comm. Johnston J).⁶ They are used in some general practice training programs in the UK^{5,7} and about half such programs in the USA.⁸

What happens in a Balint group?

A group of about 6–10 clinicians meets regularly with one or two trained leaders for between 60 and 90 minutes, over an open-ended time period, sometimes extending over some years. One or two group members present cases at each meeting, and participants are also encouraged to bring follow-up reports of cases previously discussed. Participants are encouraged to present cases where they have experienced a strong reaction, and particularly where they are experiencing difficulties.

A case is presented briefly, informally, without notes, emphasising the nature of the doctor–patient interaction and including the doctor's feelings, reactions and associations, "telling the story" of themselves and the patient, and conveying the atmosphere in the consulting room –

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what the patient is like and what it is like being with them. Group members may ask questions to clarify the presentation and then the group discusses the material presented, with particular emphasis on the doctor-patient relationship. The group members are encouraged to speculate and use their imaginations, without any pressure to be right. The aim is to understand the situation in a deeper way, not to judge, advise or offer solutions. Participants are asked to “put themselves into the shoes” of both the patient and the presenter, particularly as they encounter each other in the consulting room.

The presenter may be asked to push back their chair and remain silent after their initial presentation, and be given the option of rejoining the discussion towards the end. This gives the presenter an opportunity to listen and reflect without being under pressure and encourages a diversity of responses to the material within the group – inevitably reflecting group members’ varied personalities and life experiences.

Common issues presented in Balint groups are chronic unexplained symptoms, apparently inappropriate demands, excessive dependence, non-compliance with treatment, cultural misunderstandings, involvement of third parties (such as employers, family members and insurers), bad news, death, dying, bereavement, drug seeking and suicidality. Common reactions described by doctors regarding the cases they bring include frustration, sadness, surprise, impotence, anger, dislike, confusion, uncertainty, embarrassment, resentment, hopelessness, guilt and fear.

The essence of Balint groups

At the heart of Michael Balint’s work with GPs is the metaphor “the drug, doctor”² – how the “person” of the doctor influences the clinical encounter and outcome. Every doctor has their unique sensitivities and blind spots, and these influence what they notice in both themselves and their patient. Without awareness of one’s own and one’s patient’s experience, some clinical encounters go badly and some patients cannot be treated.

For example, common responses to the so-called “heart-sink” patient include switching off, getting them out of the consulting room as soon as possible, reflexively reaching for the prescription pad, and referring them for unnecessary tests or specialist visits. In such situations, Balint work can lead to deeper understanding and a more enlivened engagement. Even in situations where little active treatment can be offered, the group can help its participants recognise the value of empathically “being with” a patient, rather than enacting these various modes of rejection.

Balint groups have their roots in psychoanalysis as well as in general practice. The group process can be seen as a way of bringing to awareness aspects of transference, countertransference and the unconscious in both doctor and patient.⁹ The discussion might throw light on how the patient’s unconscious, internal world colours their experience of the doctor (transference). It might help to clarify to what extent the doctor is bringing a personal issue to the encounter with the patient, and to what

extent he or she carries a projection from the patient, experiencing something that is unconscious in the patient (countertransference).¹⁰ The work reflects the reality that doctors and patients all have their individual personalities, strengths, weaknesses and desires.

The group can become a safe, trusting environment in which participants risk revealing their uncertainties, and where feelings, which are sometimes painful, can be acknowledged, expressed, normalised and thought about. Sharing such feelings is often mutually supportive for participants, who feel relieved when they realise that their colleagues also struggle with their feelings at times and that strong reactions are part and parcel of the challenge of doing good clinical work.

Over time, participants may become better at integrating feelings, intuitions and reason.¹¹ They may develop better skills at dealing with difficult patients, learning to identify and contain the feelings that are evoked in clinical encounters, to reflect on them and to utilise them in understanding their patients and in addressing their needs,¹² developing their capacity to work effectively with patients who challenge them in diverse ways. Frequently reported outcomes include increased confidence and professional self-esteem, and increased competence in encounters with patients.⁸ Other positive outcomes reported include:^{8,13} increased professional satisfaction, improved psychological medical skills, increased patient-centredness, ordering fewer tests, higher levels of patient satisfaction and reduced burnout.¹⁴

Kjeldmand et al. review some key studies which provide an interesting evidence base for Balint group outcomes and thoughtfully consider some of the significant methodological challenges of such research.¹³ Other useful reviews of Balint group literature are to be found in Van Roy et al.¹⁵ and Mahoney et al.⁸

In general practice, Balint groups can help GPs understand the patient as a whole person, and become able to help a wider range of patients, including those with the many mental health issues presenting in general practice.¹²

A Balint group can feel intimate and emotional because the group discusses individual rather than generic cases and includes participants’ personal responses to them. However, the focus is on the case being presented and on participants’ functioning in a professional capacity, not on private matters.

Unlike many other educational experiences Balint work does not entail didactic teaching, imparting knowledge, or giving advice. It focuses on the person of the clinician, rather than their intellectual knowledge.

Balint groups are unique, and it is difficult to get a sense of what they are like without experiencing them. Although they can be sampled in one-off or workshop experiences, the capacities achieved by participants essentially develop gradually over time,⁵ and this needs to be considered when evaluating outcomes after brief Balint experiences.

Leading Balint groups

Balint groups are facilitated by an individual or two co-leaders. In the early days of Balint groups, leaders were exclusively psychoanalysts. Nowadays, they have a variety of professional backgrounds, commonly general practice, psychiatry, psychotherapy or psychoanalysis.

Skills needed by Balint group leaders^{5,16,17} include:

1. Understanding the task of the group and facilitating it within clear boundaries. The task is to reflect on the presented case, with particular attention to its emotional aspects and to the doctor–patient relationship and to the experiences of both the presenter and the patient.
2. Fostering an atmosphere which encourages speculation, creativity and lateral thinking.
3. Attending to boundaries common to other kinds of clinical discussion groups (such as time-keeping, protecting both participants' and patients' confidentiality, and protecting participants from intrusiveness, criticism or undue dominance by any group member).
4. Attending to boundaries specific to Balint work. Advice-giving should be discouraged: the leader should help the group remain focused on deeper understanding rather than solutions.^{9,18,19} The leader should also discourage discussion of psychiatric diagnosis and treatment and ensure that the group does not focus on participants' personal problems and become more like group psychotherapy.
5. Refraining from the temptation to share their own perspective of a case with the group. Although a skilled leader can play a role in guiding the group towards deeper understanding, the emphasis should be on facilitating the work of the group and not privileging their own perspective on the case.
6. Being sensitive to the varying needs of their particular group, so as to contain participants' anxiety (which can be considerable, especially at the beginning and in a mandatory group) and to facilitate a welcoming and helpful experience.

Leadership training generally involves some or all of: experience as a Balint group participant, co-leading with an experienced leader, supervision, leadership workshops and reading. Previous training in psychoanalysis, psychodynamic psychotherapy and group psychotherapy is also helpful.¹⁶

Balint groups in Australia and New Zealand

Balint group participants in Australia and New Zealand are generally either GPs or multidisciplinary (such as GPs, medical specialists, psychologists, psychotherapists and psychiatrists) and are led by practitioners from a

variety of disciplines, mainly general practice, psychiatry and psychotherapy. There has been some trialling and use of Balint groups in psychiatry training (e.g. Adelaide, Wellington, Sydney,¹⁹ Dunedin) and general practice training (e.g. Western Australia) and with medical students, but most groups have run privately, sometimes affiliated with the Mental Health Practitioners Network in Australia. But their use is not widespread and they have not been mandated in any national training programs (pers. comms. Betts W, Cammell D, Castle D, Davis M, Meumann F, Minett K, Minson F, Nash D, Smith V, Sullivan L, 2014). There has been some experience with Balint groups via teleconference (pers. comms. Sullivan L, Love P, 2015). The Balint Society of Australia and New Zealand, established in 2005 as the Balint Society of Australia, has a Balint leadership training pathway, is affiliated with the International Balint Federation and currently has 20 accredited leaders.²⁰ There have been some Australasian contributions to the literature.^{11,14,17,18,19,21-27}

Discussion

Balint groups are one of a number of educational approaches to clinical work which have in common small groups of peers and extended case-based discussion. It is beyond the scope of this article to review the pros and cons of these various approaches. I have highlighted what is distinctive about Balint groups: their focus on the patient–practitioner relationship, on the emotions elicited in both doctor and patient in clinical encounters, and the avoidance of seeking “solutions”. Clear boundaries and skilled facilitation can generate an enjoyable and helpful experience, a particular depth of understanding, and a safe and supportive place in which practising psychiatrists can be supported, become less defensive against the sometimes difficult feelings evoked in everyday practice, and become more skilled in recognising their feelings as providing potentially important and relevant information about their patients.

I have included a fairly detailed description of the skills required by Balint group leaders, as some psychiatrists may have an interest in Balint group leadership, both for psychiatrists and trainees, and for other practitioners. They may indeed be invited to lead Balint groups for other doctors because of their perceived expertise in psychological matters.

In Australasia Balint work mostly involves a small minority of self-selected practitioners in the private sphere. But in some other countries Balint work is offered and is often mandatory in training programs, especially in general practice, psychiatry and with medical students. Several American Balint group leaders have commented that graduates of those American family medicine residences which include compulsory Balint work often report they have appreciated their value only retrospectively.

There are many reasons why Balint work has not been widespread in Australasia. I would speculate that these include: the (incorrect) perception that it has no evidence

base; the belief that it is only of historical importance in the history of general practice; widespread lack of exposure to it and hence absence of motivation to explore it; the relatively small numbers of trained leaders; the devaluing of psychodynamic approaches in the current zeitgeist; and the fact that it is time-consuming and that some of its benefits are not immediate and develop over time; and the heavy workloads of doctors and trainees. In addition, it probably goes against the usual grain of medical education at all levels, in that it is not solution-focused. And it may be that the culture of medicine and the personalities of doctors impact on doctors' willingness to join Balint groups, which require detailed self-disclosure of the emotional aspects of their professional work and challenge their omnipotence.

I hope this article will encourage psychiatrists (including RANZCP-mandated peer groups) and trainees to explore Balint work and to consider trialling it in training programs. It can be a powerful way of learning how to deal well with doctor-patient relationships and the feelings evoked in clinical work.

Recommended reading

Together with Balint's classic book² I recommend the excellent overview of the history and nature of Balint groups together with a survey of research into Balint groups, in the two chapters by Jablonski et al. in Sommers and Launer.^{5,13}

Case example

Dr F was distressed when a patient recently diagnosed with bipolar disorder and with a past history of psychotic depression and suicide attempts stopped taking his antidepressant medication. She told the patient she could not continue to treat him unless he resumed taking it but felt awful about having threatened him in this way.

The group articulated how anxiety-provoking it might be to be responsible for a potentially increasingly disturbed, suicidal patient and how this might be too difficult to tolerate. The group also speculated about why the patient had stopped the medication, and about what the doctor's threat to stop treating him might mean to him.

Dr F could be seen as struggling to contain her anxiety sufficiently to explore the reasons for the patient's non-compliance. The group does not explore why Dr F might be particularly vulnerable to such anxiety, but focuses on the clinical encounter. Nor does the group give Dr F advice about what to do. This would most likely be unhelpful, as she is a competent doctor and already has an intellectual understanding of what to do but has been unable to articulate this clearly to herself and act on it.

Disclosure

The author reports no conflict of interest. The author alone is responsible for the content and writing of the paper.

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