INTRODUCTION TO BALINT GROUPS

"There's nothing like a difficult patient to show us ourselves"
– William Carlos Williams

Case-based presentation in a peer-group setting, focusing on the doctor-patient relationship and the patient as a person in order to improve interaction with, management of, and physician feelings about the patient

I. HISTORY OF BALINT GROUPS: THEN AND NOW

1. Started for experienced family physicians in England by psychiatrist Michael Balint and his wife Enid
2. Prevalence of Balint groups in family medicine training programs: 1990 survey – about 20% of FM programs had Balint groups
3. Membership
    a. Can be either peers at same level of training, or mixed groups (incl. Students, residents, faculty, community physicians)
    b. Usually between 5-10 participants – only 10% had > 10 members
4. Frequency:
    a. Meet either weekly (50%), twice monthly (25%), or once monthly
    b. Usually 1-2 year commitment
5. Group leaders
    a. About one-third of Balint facilitators are physicians, 25% are psychologists, and about 20% are social workers
    b. In 50% of cases, a physician co-facilitates; and in one-third of cases, psychologist or social worker co-facilitates

II. DEFINITION – TRADITIONAL BALINT GROUP

1. Studies doctor-patient relationship to understand the patient as a person and the effect this has on the physician, the illness and its management
2. Each seminar begins with spontaneous, unscripted case presentation from one of its members.
3. Psychological (originally psychoanalytic) insight is used as a therapeutic tool
    a. Focus is on process issues in doctor-patient relationship, not on issues of content and management
    b. Emphasis is on professional, not personal self-disclosure; not individual, group therapy
4. Group members try to imagine what it is like for the presenter to treat this particular patient
5. Group leader keeps discussion focused on speaker's feelings as s/he presents case; draws attention to the group process when it parallels doctor-patient relationship
6. Intra-group dynamics are discussed only when they pertain to dissatisfaction with group process, irregular attendance, or uneven participation by group members
7. Leader avoids discussion that involves personal or family information about group members

III. BALINT-STYLE GROUPS

1. Balint-style groups compared to traditional Balint groups:
    a. Emphasize more support, reassurance to relieve anxiety, protection of members
    b. Include more directed teaching and guidance
    c. Focus more on cases or issues than personality of physician
    d. Are more solution-, answer-oriented rather than oriented toward process and self-discovery
2. Goals in common:
    a. Focus on problematic patients
    b. Exploring issues in doctor-patient relationship that create difficulties for physician
    c. Promotion of professional development and personal growth

IV. GOALS AND OBJECTIVES

1. Overall goal: "limited, though considerable" personality change in physician – limited to physician's professional functioning
    a. Ability to think differently about patients through process of accurate identification with and responsiveness to the patient
    b. Ability to accept limits in patient care with humility rather than resentment and disillusionment
    c. Ability to become aware of "blind-spots" in interactions with patients
2. Objectives of Balint groups:
    a. Provide support for residents, esp. intragroup intimacy and cohesion, trust
    b. Help resolve professional role conflicts
    c. Determine effect of patient's and doctor's personalities on illness
    d. Understand patient as a person

V. CONTENT AND SKILLS

1. Issues typically addressed in Balint groups:
    a. Conflicts interfering with patient care
    b. Feelings of MD
    c. Unrealistic patient demands
    d. Professional role delineation (boundaries and expectations)
    e. Topics such as death and dying, family problems, psychosomatic issues, noncompliance, chemical abuse, domestic violence, chronic illness, culturally different families, fear of AIDS, delivering bad news
2. Attainable skills include
    a. Recognition of feelings generated when with patients
    b. Increased ability to pay close attention to patients, self; step back more easily from patient-exerted pressures and examine their meanings
    c. Increase in ability to be curious about and investigate patient behavior that was previously dismissed as irrational
    d. Acceptance of, connection with patients
    e. Increase in compassion, genuineness, trusting relationship with patients

f. Expanded repertoire of personal styles to use with patients
g. Improved management of previously intolerable or frustrating patients
h. Sense of professional self-worth

V. HOW BALINT GROUPS WORK

1. Initial check-in – up-date on previous cases
2. Opening question: Who's got a case?
    a. Not a formal presentation – avoid excessive medical detail
    b. Focuses on interaction between doctor and patient
    c. Focuses on physician feelings of discomfort (anger, helplessnessness, hopelessness, depression, frustration, guilt, perfectionism, over-identification with patient, being controlled or manipulated by patient etc.)
3. Stick with actual case
    a. Not what we do with patients like X
    b. Rather, what can you do with this patient at this time
    c. Watch over-generalization, stereotyping
4. Role of moderator
    a. Listens, facilitates discussion
    b. Avoidance of expert role
    c Keeps focus
    d Does NOT provide magic answers
    e Encourages playful speculation
    f. Lets group do the work and learn from each other
5.Balint interaction
    a. Avoid excessive interrogation of presenter
    b. Avoid premature closure
    c. Imagine physician's feelings
    d. Imagine patient's feelings
    e. Disclose own feelings as they are stimulated by the case
    f. Use of common sense, rather than labeling
    g. Address questions
        1.What's going on here?
        2.What's causing these feelings?
        3. What's happening between doctor and patient?
        4. Let's look at this from a different perspective
    h. Be willing to tolerate uncertainty, doubt:
        1."Don't just do something, stand there"
        2. Two kinds of physicians: those who from time to time experience self-doubt; and those who don't but ought to
    i. Playful speculation
    j. Suggestions: What might be done differently?
        1. About relationship/interaction
        2. About physician reframing
        3. About patient management
5. More than one case can be presented