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BALINTING BALINT:
THE RESUSCITATION OF A RESIDENT BALINT GROUP

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Abstract

The author tells the story of a resident Balint group's struggle over an academic year. In dealing with their dissatisfactions, the group embarked on variations from traditional Balint work in order to breath new life into a failing group experience. The story is used as a platform from which to examine the central and essential features of Balint group work as well as to pose bigger questions about Balint groups in residency training.

**BALINTING BALINT:
THE RESUSCITATION OF A RESIDENT BALINT GROUP**

I look at my watch. It says a few minutes after 4 o'clock. I've had a non-stop day of meetings, private clients, groups, peer consultation, Faculty Balint, and now it is time for Resident Balint. The residents' 3 o'clock lecture is running over time. This group usually drags their feet getting to Balint. I dread going to the conference room to announce the start of Balint, urging them to come to group, cajoling them so we can get started and actually have adequate time for a case. Part of me feels like a sheepdog, nipping at the heels of recalcitrant sheep. I know the residents have had a busy day, a busy week, a busy month, and a busy year. I know they are cumulatively or acutely sleep deprived. I know part of them would prefer to finish their charts or return emails or go exercise before the sun sets, or spend time with their significant other or take a nap or just go home early for once. Anything rather than sit and reflect and muck about in less than conscious emotional processes. These are family medicine residents who like to solve problems, to help patients and to fix them. They are afraid they might kill their patients if they don't learn enough "real" medicine. Reflection seems irrelevant, boring and soporific to them. Thinking about problematic patients for an hour seems tortuous after their long day. I am concerned they will grow to dislike and avoid Balint for the rest of their careers.

Assessing the situation

I don't often get a chance to present a case, but today I will by continuing the above narrative of what happened over the course of an academic year in one of our Balint groups for resident-physicians.

First, some background about the structure of our Balint groups: Our two concurrent resident Balint groups contain both second and third year residents. Groups meet twice monthly except for holidays. Residents are expected to attend, with attendance taken, except for vacations, time away on elective rotations, and when they are on call, post call or in the hospital. Each group averages about six to eight out of twelve possible residents plus the two credentialed leaders. Balint takes place on Thursdays, from 4 to 5 PM at the end of an afternoon of conferences in which the residents have been sitting since 1 PM. They are anxious to finish charting, get outside to exercise, or go home. Many, though not all, believe that Balint is not central but something thought of as esoteric or peripheral to their training.

The residents usually arrived late to group. They often asked if we could hold group outside (where, because of traffic noise, it was difficult to hear, not to mention maintain confidentiality). They complained about the Balint format of calling for a case, uninterrupted presentation, clarifying questions, virtual push back, group work, and then inviting the presenter back. They perceived the format as rigid, predictable, boring, rule-bound and injurious to their sense of spontaneity and creativity.

Some residents were so cumulatively sleep deprived they fell asleep during group. Others were anxious or bored and entered into distracting side conversations.

One very concrete resident often began changing into his bike shoes about fifteen minutes before the end of group to signal he had had enough. They often grumbled to others, outside of group, about what a waste of precious conference time Balint was. They would ask the leaders if they were "doing it right", with only slightly disguised disdain. Most times these expressions of dissatisfaction and disinterest were indirect. I grew frustrated with this indirectness.

The group felt stagnant, stale and sluggish to me, and I imagine to them also. Troubled, I spoke with my co-leader. I presented the situation in consultation with the other group Balint leaders. I was uncomfortable holding their dissatisfactions. Progressively I grew more and more convinced that we needed to have an open conversation in group about what was and was not happening.

Opening a blocked airway

At one group, when they once again seemed to be expressing their dissatisfactions indirectly, I invited them to talk about how Balint was going for them. At first slowly, then more freely, their dislike of Balint poured forth: "Why do we have to do Balint?" "We talk about patients with each other all the time." "There are too many rules in Balint and I can never do it right." "I just don't like Balint."

I listened carefully, working very hard to listen, to understand and let them know I was trying to understand their perspective. I prepared myself to not feel personally attacked or defensive, and not to attack back or explain away their objections. I tried to show them I was listening to their complaints and taking them seriously. They were surprised I would entertain such a discussion about something I believed in so passionately. I thought it a gamble, but one I felt had to be taken if the group were to be resuscitated.

I asked them how they wanted to use this time to learn how to better deal with difficult or troubling interactions with their patients. I told them that if they didn't like the usual Balint format, why not suggest alternatives they might find more helpful. This threw them back upon their own resources and challenged them to think about what they wanted to do. Initially they were flummoxed by this question. They only knew that they did not like Balint.

Starting chest compressions

Soon ideas started to bubble up. Over the next several groups, we tried out some of these ideas. Their first idea was not to spend the entire hour on one case. They wanted to try multiple presentations, each shorter than the usual case. Any silence would elicit a call for the next case. After each short case, someone suggested we all stand up and take a different chair for the next case. (I think they especially loved being able to move their bodies at the end of the day.) We called these shorter, rapid-fire cases "Lightning Balint".

Then they suggested trying a process in which we would take turns, going around the circle, each voicing a sentence or phrase or quote, whatever came to them, which, hopefully, at some level, would be connected to the case. They next

suggested going around the circle in the opposite direction doing the same thing. At first the comments seemed disjunctive and disconnected, but soon seemed to make sense as the residents began to draw from their less than conscious processes to represent some aspect of the patient or physician. We called this "Renga Balint", a reference to a genre of Japanese collaborative poetry writing.[1]

They proceeded to suggest other variations; one in which half the room would focus on and try to verbally represent the patient's perspective and half the group would represent the physician or presenter's perspective, again going around the circle in order. Then we tried to not go in any specific order, which made some of the quieter residents feel less on the spot. I think they felt surprised and gratified to be offered the possibility of varying the usual format.

Over the ensuing sessions they suggested several other variations. I continued to push them to take responsibility for making the hour meaningful to them. Instead of beginning these sessions with my usual "Who's got a case?" I now began sessions by saying, "What are we going to do today?" After four or five of these sessions, one third-year resident said that although she was really enjoying all the creative ideas the group had tried, she "really missed spending a little more time on each case–– maybe we could do just two or three in the hour", instead of the rapid fire Balint we had been practicing. We spent the rest of the academic year alternating between doing two or three cases per session and experimenting with other creative formats suggested by the residents. I held fast to my new mantra: "What are we going to do today?" I wanted the group to become actively engaged in charting its own course. And it did.

Post-code reassessment

As long as things are working well, there is no need to reflect on what is happening. But when things are not going well, we need to look at what <u>is</u> working and what is <u>not</u> to help us understand how to make things better.[2] When the resident Balint group was not working and we varied the usual method, it provided an opportunity for me to reflect on the important aspects of Balint work, and whether what this group did could still be called Balint.[3]

In order to overcome this group's dissatisfactions with and withdrawal from what they perceived to be the constraints of the usual Balint method, I invited the residents to overtly discuss their dissatisfactions in group, rather than have them indirectly act out their discontent. I tried to help them find ways that engaged them in a process to better understand problematic relationships with their patients without sacrificing the central and valuable aspects of Balint work. Instead of feeling like they were forcing themselves to fit into a method they didn't identify with, they were invited to work at creating their own method.

This was not traditional Balint. Could it still be called Balint at all?

In reflection, I absolutely see what we did as a form of Balint work: The residents were presenting cases, feeling, thinking about, and imagining interactions with

patients in a group. They were open to taking in a variety of possible interpretations about the physician-patient relationship, some conscious, some not.

They actively participated and became engaged in presenting patient cases and working at trying to understand the cases of others; they were awake and generative, curious and creative and invested.

The group became a safe and stimulating place for residents to learn about their disturbing interactions, blind spots and stuck points without being shamed. They learned they were not the only ones who had irrational feelings, who made mistakes or had trouble with patients. They learned to access their less than conscious emotional reactions and experiences and learned to use their reactions to better understand their patients, their colleagues' patients, their colleagues and themselves.

They began to appreciate the emotional depth and complexity of physician-patient relationships and to see multiple meanings and levels of meaning in these relationships. They let go of finding "the right answer" or too rigidly following the unwritten "rules" of Balint. They learned not to take their patients' behaviors too personally, to work at differentiating their issues from their patients' issues, to become aware of the difference between facts and perceptions and between solving problems and understanding problems, and to know when each was called for.

Even though the group experimented with variations of the traditional Balint format, what we did was truly the heart of Balint.

Long term survival prognosis

The experience of working with this group raised provocative questions for me as a Balint leader. These questions include:

First, do we give enough attention to residents' developmental needs? Some residents are so worried about gaining enough medical knowledge and learning procedural skills that they have difficulty engaging in Balint work.

Second, when we require residents to attend Balint groups, are we putting our own needs to teach the traditional Balint method and format before their developmental needs? Would resident Balint groups be better if they were optional or voluntary or open to variation of method?

Implications for future resuscitations

In conclusion, I believe it crucial for Balint leaders in training sites to find ways to keep their groups invigorated and inspired or to resuscitate groups that are failing. The way I found myself resuscitating my failing group was to "Balint" Balint; to invite the residents to directly and overtly address their dissatisfactions in the group and to suggest what they wanted to try in our time together. I wanted them to feel the relevance and saliency of the group work. They were not just passively learning a fixed method.

Group leaders must be open to the possibility of "Balinting" floundering Balint groups, especially during residency training. Unless we allow resident-physician group members to experience ownership in their resident Balint group, they may never choose to participate in a Balint group again after their training and Balint may exist as a small esoteric method, attracting only a very few participants. Leaders need to clarify what are the central and essential elements of their Balint work.[4] Mine included: working to better understand the subtleties and complexities of the patient, the physician and their relationship; encouraging the reflective emotional experience of the group members; using the power of the group; and allowing for the emergence of subconscious as well as conscious material. These elements need to be included whether a group uses a traditional or non-traditional format.

My overarching goal for the residents has been and continues to be to help them take better care of their patients and come to enjoy their relationships with their patients over time. I hope they will begin to experience the value of Balint work during their residency so they will hunger for more Balint after their formal training; so they will return to some sort of reflective, experiential group process in their later practice; and so they can experience the stimulation and nourishment and aliveness that an ongoing Balint group provides for so many physicians throughout their professional careers.

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