American Balint Society Newsletter

Annual Meeting Edition
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A practical "how-to" conversation continues with a series of thoughtful contributions from a widening variety of Balinters. Keep the conversation interesting by sending your ideas to:
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As always, you will be thrice blessed for sending diskettes, any format, for PC or Mac!

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Balint Groups and Personal and Professional Development Groups:

I. Contrasting the Role and Function of the Leader/Facilitator

Frank Dornfest, Ritch Addison, and Don Ransom

As we have talked to group leaders and Training Directors around the country, we have noted some confusion about what constitutes a Balint Group, especially in contrast with what constitutes a Personal and Professional Development Group, the two dominant types of groups found in Medical Residency Training settings. In the Newsletter dated September 29, 1992, we generated a list of categories we thought were helpful in exploring the similarities and differences between these two kinds of group learning experiences:

- Purpose of the group
- Function of the group
- Process of the group
- Implicit norms of the group
- Focus (object of inquiry) of the group
- Organizational structure of the group
- Relationship to program
- Role and function of leader/facilitator
- Training of leader/facilitator

In this issue, we discuss one of these topics, the role and function of the leader or facilitator. Although the following comments are drawn to apply to groups in a residency training setting, differences may hold for other practice situations. We also recognize that, although we describe differences in general (a non-Balint sort of thing to do), the specific roles and functions of Balint leaders and Personal and Professional Development Group facilitators will vary depending on the composition, commitment, age, experience, and cohesiveness of the group, as well as on individual differences of the leader/facilitators.

Self-Disclosure

Personal and Professional Development Group facilitators can self-disclose but usually only upon invitation of the group. However they must not do so repeatedly to allay the anxiety of the group members. When anxiety is high in a group and members do not feel safe, members often find it immediately reassuring for the facilitator to self-disclose. Facilitators must draw a balance between absolute refusal and automatic acceptance to self-disclose, maintaining a friendly, welcoming atmosphere while judiciously resisting the groups’ desire to escape their anxiety by looking toward the leader. In Personal and Professional Development Groups, members often decide that they will "check-in" (talk briefly about how they are feeling, what concerns them, what is happening in their life or work) at the start of each group. At some point, they usually invite the facilitator to do so also. Few Personal and Professional Development Group facilitators decline to do so. Most check-in, but do briefly and genuinely so as not to usurp members’ time.
This is not the focus of Balint Groups. It is the role of the Balint leader to focus always on a case. This is based on the idea that general discussion of the sort described in Personal and Professional Development Groups is an escape from the anxiety of discussing the case. Self-disclosure by leaders of Balint groups can occur for a variety of reasons, and the decision to do so hinges on whether it furthers the group process at that moment, although in general this is not seen as helpful to the group work. When a group member asks what the leader is thinking or what the leader might do in a particular situation under discussion, whether to answer directly or not is a strategic issue, not a matter of principle or ground rules. Since one of the leader’s roles is to keep the group working, it is often preferable to turn the question to other members of the group first. This does not mean always saving the leader’s answers routinely until the end, either, because this sets the expectation that the oracle speaks at the close of the session, a bad habit for both leader and group.

When the leader self-discloses, it is usually to get the group moving and to model how that might be done. Sometimes this means taking a "flying leap" at what is going on or what to do, to deflect the group from continuing simply to ask the presenter questions. This is also a way of taking the spotlight off the presenter and opening up other possibilities for thinking about the case.

We are talking here about "professional role" self disclosure, not personal self-disclosure. In few instances is such personal disclosure relevant or "in bounds" in Balint groups. Unlike a therapy group, a Balint group is bounded by the professional roles of the participants. There is little doubt that working to understand and enlarge the possibilities of this role generalizes to some change in personality for participants who get meaningfully involved in the process. However, this is an indirect and unintended effect, not an aim of the method. One of the functions of the leader is to monitor the boundary of the personal and professional selves being discussed in order to protect the members and the process from both inappropriate inquiry and personal self-disclosure.

Dealing with Anxiety

Although it is not possible or even desirable to completely allay the anxiety of residents, Personal and Professional Development Group facilitators function (especially initially) to minimize anxiety so that the group becomes a supportive place for residents to explore their feelings, attitudes and beliefs as they progress through residency. This is a major difference between Balint and Personal and Professional Development Groups.

The Balint leader almost never tries to reduce the anxiety created by the presentation and discussion of a case. On the contrary, as in the psychoanalytic tradition, a reasonable level of anxiety is viewed as a condition of work. If anything, the leader needs to direct the discussion most of the time in ways that may elevate the anxiety level when the group colludes to discuss issues that are too safe. Group members may collude to avoid talking about anxiety provoking
material, but in so doing they also may get bored and sometimes resentful, feeling like they are being "coddled" by each other and the leader. When the anxiety level seems high and also seems to impede a productive discussion, the Balint leader often puts into words what is going on in the room: "I sense from x and y that a good deal of depression is floating in the room. Does the group have an idea of what that's about?" This is a standard leader maneuver for freeing the discussion up to move again.

**Intervention**

In Personal and Professional Development Groups, facilitators may have to intervene to spread out participation among all the members of the group. Facilitators must protect quieter members from the domination of more monopolizing members. Facilitators actively help members deal with a potentially damaging conflict within the group, mediate between conflicting members, ask after the well-being of absent members, and seek out members who evoke concern.

The Balint leader has a narrower and more focused sense of what is useful or not useful to be talking about, at any given moment. The sense is one of having a compass and a seismometer to note the direction and intensity of the group continuously. Another way of saying this is that the Balint leader is freer to be evaluative and exercise a judgment about what group and presenter behavior furthers the work of the group. When the discussion moves the wrong way, and no member redirects the course within a few minutes, the leader intervenes to do so.

A balance must be struck between intervening too soon and excessively, and thereby contributing to a learning context in which the members wait for and rely on the leader to steer and re-focus, and waiting too long, and, thus, letting the group flounder or get the wrong idea about what it is they should be talking about. An example would be getting into a debate or too much detail about what the particular traditional medical or psychiatric diagnosis of a patient might really be.

The inclinations of an inexperienced Balint Group leader generally fall on one or the other of these extremes. In particular, too much faith can be put on the notion that the group can and must learn from its own mistakes—that they will self-correct if given freedom to correct their own course. But more often, they flounder, repeat unhelpful patterns, and lose interest. A sense of failure or, at least, a lack of feeling they are getting something out of the process sets in and morale goes down. Then the leader has repair work to do. It is better not to let the group wander off too far for too long and get themselves into this kind of situation.

Another way to put this is that the group leader continually monitors and maintains the frame and boundary and guides and protects the process. For example, if the group colludes with the presenter to make only the patient the problem, the leader would intervene and speak for the patient, insisting that there is another point of view within the relationship and suggesting that not
INTRODUCTION TO BALINT SEMINARS

Lee Scheingold, M.S.W.

Michael Balint was a Hungarian/British psychoanalyst who maintained a lifelong interest in the application of psychological principles to the practice of medicine. Beginning in 1950, he and his wife Enid led groups of general practitioners in case discussions of physician-patient relationships at various clinics in London. In his well known book, THE DOCTOR, HIS PATIENT, AND THE ILLNESS, Dr. Balint set forth some of the principles which emerged from his first seminars. These case discussion groups have had a powerful influence on general practice medicine throughout the Commonwealth, and are gaining increasing popularity in family medicine training in America.

Discussion in the groups centers around a specific case interaction from hospital or clinic. Specific goals of Balint group training are more in the area of attitudes and skills than of knowledge. In a Balint group physicians:

1. present cases to the group with a focus on feelings and interpersonal interactions rather than on medical issues;

2. use their own awareness of and insight into feelings to shed light on difficult physician-patient interactions;

3. respond to presentation of other group members with questions and comments.

It is hoped that during and after
participation in a Balint group, physicians will be able to

(1) handle more comfortably patients who had previously been intolerable or frustrating to care for;

(2) develop a variety of personal styles with patients rather than maintaining the same structured medical interview for all;

(3) step back more easily from patient-exerted pressures and examine their meanings;

(4) critically analyze the process of a consultation afterward with an emphasis on their own response to the patient's behavior; and

(5) exhibit a nonjudgmental curiosity about patient behaviors that they may previously have labeled irrational.

The atmosphere of a Balint group, which is composed of eight to ten physicians and often led by a mental health professional, is that of a rather free give and take, in which everyone can bring up problems in the hope of learning from others. The focus is often on the physician's emotional response to the patient, and the following questions are typical of what might be asked of the presenting physician:

--What was the patient's actual reason for coming that day?
--How did you feel when you saw the patient's name on your list?
--What kinds of thoughts and feelings did you have?
--Are there other patients who make you feel the same way?
--What are alternative ways of handling this situation which may be more comfortable for you?

In sum, a Balint group's main aim is to understand the physician-patient relationship. It often turns out to be supportive, although the goal is professional development, not personal therapy.

For further reading, please see attached bibliography.

See the fall '91 issue for another Balint bibliography - Ed.

A Brief (far-from-complete) Bibliography for those interested in Balint work and physician-patient relationship issues