Residency Education

The Current Status of Balint Groups in US Family Practice Residencies: A 10-year Follow-up Study, 1990–2000

Alan H. Johnson, PhD; Clive D. Brock, MD; Ghassan Hamadeh, MD; Ron Stock, MD

Background and Objectives: *In 1990, the first and, to date, only objective study of Balint groups in US family practice residencies was conducted to measure their prevalence, composition, leadership, and function. The study reported here collected similar information about Balint groups.* Methods: *Surveys were sent to all 464 US family practice residency program directors, with a 1-month follow-up to nonrespondents. The survey included questions about the existence, leadership, meeting frequency, and objectives of Balint training.* Results: *A total of 298 (64%) residencies responded. Almost half (48%) of US responding residences reported conducting Balint groups, and 40% of those residencies have more than one group. The frequency of Balint group meetings has shifted in the past 10 years. In 1990, 55% of groups met weekly; in 2000, only 15% of groups met weekly. Sixty-five percent of residencies require Balint participation. One third of Balint groups are conducted without a coleader, and the number of physicians leading groups is 22%, a decrease of 10% from 10 years ago. Forty-four percent of groups are led by psychologists, an increase of 19% from 10 years ago. Respondents indicated uncertainly about whether their groups were true Balint groups or simply resident support groups.* Conclusions: *About half of US family practice residencies operate groups described as Balint groups. They meet less frequently then 10 years ago and are less likely to have a physician involved in group leadership. Some of the groups may actually be support groups rather than Balint groups.*

(Fam Med 2001;33(9):672-7.)

From the 1970s, Balint or Balint-like groups have come into and out of existence in US family practice residency programs. Individual residency programs featuring Balint groups were profiled in the early 1980s by Scheingold and Brock.[1,2] However, the coordination of a sustained, national effort to spread the research, teaching, and practice of Balint's work did not really begin until May 1990 when the American Balint Society was formed concurrently with the 1990 annual meeting of the Society of Teachers of Family Medicine (STFM). STFM's educational efforts from 1990 to 2000 and the defining values directing the American Balint Society's mission were described in a recent article by Johnson.[3]

The first and only report to date on the prevalance, composition, leadership, and function of Balint groups in US family practice residencies was published in 1990.[4] More-recent studies cite the contribution of Balint activities to family practice residencies without quantifying these activities.[5,6] Our current study updates the profile of Balint activities in US family practice residencies.

From the Department of Family Medicine, Medical University of South Carolina (Drs Johnson and Brock), Department of Family Medicine, American University of Beirut (Dr Hamadeh); and Sacred Heart Medical Center, Eugene, Ore (Dr Stock).

Methods

Sample and Mailing Procedures

In April 1999, a computerized list of family medicine program directors was purchased from STFM. In May of that year, a four-page, two-part questionnaire was mailed to each director, along with a cover letter. The cover letter stated that the enclosed questionnaire was a 10-year follow-up survey by the American Balint Society to assess the current composition, leadership, and purpose of Balint training in US family practice residencies. The directors were asked to complete the questionnaire or forward it to a person in their program who could complete it and then return it to us. One month later, all programs from which no completed questionnaire had been received were sent a second copy of the questionnaire with a letter requesting completion and return of the survey.

Instrument

The content of the questionnaire paralleled the content of the 1990 survey by Brock and Stock. Part I of the questionnaire focused on whether residencies had Balint groups and, if not, whether they ever had such groups in the past 10 years. For those with past groups, the questionnaire asked about reasons for deactivation. Those without Balint groups were also asked about intentions to initiate groups. If the program had no Balint group(s), the questionnaire could then be returned without continuing to Part II of the questionnaire.

Part II of the questionnaire contained questions about the composition and numbers of Balint groups, frequency and duration of group meetings, professional role of leader(s), how leaders were trained, and how they maintained their leadership skills. Finally, several Likert-scale questions were used to identify the goals of the Balint group, with a score of 5 indicating that the identified item was an important goal of the group and a score of 1 indicating that the item was not an important goal. These items were developed around a set of values directing Balint training and research (Table 1).

After receiving returned questionnaires, we reviewed them to identify conflicting or ambiguous responses. We then contacted respondents by telephone to clarify those responses.

Data Analysis

Data are reported with simple descriptive statistics. The result of Likert–scored questions were analyzed for significant differences in mean scores using *t* tests.

To check for bias, several basic program parameters of responding programs were compared to the programs that did not respond. The *1999 Directory of Family Practice Residency Programs* was used as the source of program information.[7] Program structure, residency location, number of family practice centers per program, total number of residents, year of initial approval (age of program), resident-to-faculty ratio, and physician-to-other-faculty ratio were compared between the two groups by using chi-square tests.

Results

Respondents

A total of 298 (64.2%) programs responded to the survey, and 166 (35.8%) did not. We found no significant differences between responding and nonresponding programs for program structure, location, number of family practice centers, number of residents, age of programs, and faculty-resident ratios.

Presence of Balint Groups

Table 2 summarizes the results of Part I of the questionnaire and, where possible, compares responses to those on the 1990 survey. The number of residencies reporting a Balint group has more than doubled from 1990, increasing from 66 (19%) programs to 144 (48%) programs having a Balint group. Forty percent of the programs that responded are conducting more than one Balint group.

Of those without Balint groups, 21% had one in the past 10 years, and 6% planned to start one in the coming year. Very few residencies without Balint groups indicated reasons for their absence in the residency, but the most frequently cited reasons were lack of resident interest, lack of faculty interest, shortage of time, and Balint group leaders leaving the program.

Table 3 summarizes 2000 data on the membership of 228 groups in 142 residencies and, where possible, compares data to the 155 groups in 66 residencies that

Table 1

Values That Direct Balint Training/Research

Goals to Be Achieved	*Goals to Be Avoided*
Spontaneous case presentations: omissions, emotions, slips of the tongue, and metaphors	Assigned presenter and defined format for presentation
Relationship focused on two whole people coping with an illness	Treating a sick patient: *ICD-9* or *DSM-IV* status explored
Group is to imagine and explore experience of presenter with one patient	Case generalizations and treatment protocols are discussed
Group process is monitored to see how it parallels the doctor-patient relationship	Group activity is judged by product or prescription for treatment
Leader diverts group from psychologically probing presenter	Therapy group explores psychological structure of presenter
Quality of group process is analyzed only if it is obstructing group task	Training group focuses on all-group process to highlight small-group dynamics
Training for the professional ego (what kind of doctor do I need to be for this patient?) ". . . a considerable though limited change."[8]	Psychotherapy for the personality (what kind of person do I want to be?)

ICD-9—International Classification of Diseases, Ninth Edition
DSM-IV—Diagnostic and Statistical Manual, Fourth Edition

Table 2

Balint Groups in US Family Practice Residencies in 1990 and 2000

	SURVEY YEAR			
	1990		2000	
	#	%	#	%
Programs surveyed	381	100	464	100
Respondents	354	93	298	64
With Balint	66	19	144	48
Residencies with:				
One group	—	—	87	60
Two groups	—	—	33	23
Three groups	—	—	20	14
Four groups	—	—	4	3
Without Balint	288	81	154	52
Would like one	69	24	8	5
Plan one in 1 year	—	—	9	6
Had one	33	11	33	21

were described in the 1990 report. Most Balint groups were of mixed membership, with the highest percentage of groups (64%) containing first-, second-, and third-year residents. No peer groups of only medical students were found in the 2000 sample. The percentage of faculty and community physician Balint groups changed little between 1990 and 2000. The distribution of numbers of participants in Balint groups also remained fairly constant, with 73% consisting of 5–10 members.

Frequency of Group Meetings

What seems to have changed most between 1990 and 2000 is the frequency of meetings. In 1990, 55% of groups met weekly; in 2000, only 15% met weekly. However, in 1990, 11% of groups met monthly; in 2000, 48% of groups met monthly. The duration of Balint groups remained fairly constant over the past 10 years, with about half of the groups lasting for 3 years (ie, the duration of residency training). Balint group participation is now required by 65% of programs, which is higher than the estimated approximately half of programs that required Balint group membership in 1990.[4]

Leaders

Table 4 summarizes data on leaders and coleaders. In 2000, 33% of the groups in the sample operated with a leader only (ie, without coleaders). The number of family physician leaders decreased by 10% over the past 10 years, and the number of psychologist leaders increased by 19% over the same period. From 1990 to 2000, the number of family physician coleaders decreased by 9%, and the number of psychologist and psychiatrist coleaders decreased by 10%. The percent representation of other professionals in Balint groups changed little.

Table 5 summarizes the 2000 data on leaders' methods of study and peer review. Reading, together with STFM workshops and consultations with other leaders, was the chief method of studying Balint leadership skills. However, few leaders sought consultation on their leadership from outside their programs. To varying degrees, leaders seem more consistently to seek feedback on group process from their coleaders. Only 52 persons cited formal intensive leader training as an avenue of studying Balint group leadership.

Table 3

Balint Group Characteristics in 1990 and 2000

	SURVEY YEAR					
	1990		2000			
	#	%	#	%		
Mixed	63	55	108	47		
Peers only	52	45	120	53		
					Mixed	
Participants					#	%
Medical student	1	2	0	0	10	4
PGY-1	19	36	49	21	119	52
PGY-2	14	27	32	14	128	56
PGY-3	13	25	30	13	117	64
Faculty	3	6	9	4	44	19
Community physician	2	4	0	0	4	2
Members in each group						
Less than 5	9	7	25	11		
5–10	87	76	167	73		
11–15	11	10	31	14		
>15	1	1	5	2		
Unknown	7	6				
Frequency of meeting						
Once a week	63	55	34	15		
Twice a month	30	26	58	25		
Once a month	13	11	109	48		
Every other month	1	1	0	0		
Unknown	8	7	0	0		
Variable			26	11		
Blank			1	0		
Duration						
3 months	3	3	2	1		
6 months	2	2	1	0		
1 year	35	30	57	25		
2 years	14	12	36	16		
3 years	42	37	74	32		
Unknown	19	16	3	1		
For the duration of training			55	24		
Participation						
Voluntary			61	27		
Required			148	65		
Other			18	8		
Blank			1	0		

PGY—postgraduate year

Group Objectives

Table 6 summarizes the average ratings, on a 5-point Likert scale, of possible Balint group objectives. Where possible, the ratings of objectives in the 1990 survey are compared with those of the 2000 survey. Of those objectives that were the same in both surveys, the same items were ranked in the top five: (1) understanding the patient as a person, (2) determining the effect of doctor's personality on the illness, (3) providing support for residents, (4) helping physicians resolve professional role conflict, and (5) determining the effect of patient's personality on illness.

The ranking of the objective "providing support for residents" dropped from 1990 to 2000, but unavailability of the 1990 survey data makes it impossible to determine if this difference is statistically significant. However, if one groups the 2000 survey data into two sets, those with leaders who have formal Balint leadership training and those whose leaders do not have such training, significant differences were noted in the rating of the importance of two objectives: "providing support for residents" and "helping physicians resolve professional role conflict."

In both the 1990 and 2000 surveys, few respondents indicated that an important goal of a Balint group was for teaching about psychiatric terminology, the use of psychotropic medication, training in family therapy, or management or counseling strategies for psychiatric illness.

Discussion

Leader Training

There has been an increase over the past 10 years in the number of residencies offering Balint groups. During this same period, the American Balint Society has offered training opportunities for Balint group leaders,[3] but less than half of the respondents have attended one or more of these formal training opportunities (Table 5).

The American Balint Society is concerned about the ongoing, continuing education of Balint leaders. Only 23% of the respondents in this survey had attended an intensive leadership training workshop; 74% of the leaders or coleaders do not receive feedback on their leadership from anyone outside their residency; one third of the groups surveyed have no coleaders. When these data are further modified by the fact that approximately 12% of the time coleaders don't review group process, one must seriously question how the paradigm of learning is being met: experience plus feedback. The American Balint Society would recommend that all Balint leaders and coleaders seek formal Balint training and that physician and behavioral scientists work in tandem. They each have significant insight to contribute to an understanding of clinical practice and group dynamic processes.[10] We were pleased to note that of the 228 Balint groups surveyed, 146 had family physicians serving either as leader or coleader.

Table 4

Composition of Balint Group Leaders in 1990 and 2000

	SURVEY YEAR			
	1990		*2000*	
	#	*%*	*#*	*%*
Leader				
Family physician	25	32	50	22
Psychologist	19	25	100	44
Social worker	15	19	38	17
Psychiatrist	4	5	9	4
Psychoanalyst	5	7	7	3
Other	9	12	23	10
Blank			1	0
Total	77	100	228	100
Coleader				
Family physician	28	51	96	42
Psychologist	10	18	19	8
Social worker	6	11	12	5
Psychiatrist	8	15	11	5
Psychoanalyst			2	1
Other	3	5	10	4
No coleader			76	33
Blank			2	1
Total	55	100	228	100

Table 5

How Balint Leadership Skills Are Acquired and Maintained in 228 Groups*

Study methods	*Alone*	*With Other Techniques*
Reading	22	209
Formal training	2	52
STFM workshop	2	115
Sharing transcripts	0	22
Other leaders	1	98
Coleading	0	44
Other	8	63
Do you review group process with a coleader?		
None of the time	18	
Some of the time	66	
Most of the time	46	
All of the time	26	
Do you receive outside feedback on your leadership?		
None of the time	153	
Some of the time	45	
Most of the time	2	
All of the time	7	

* All items were not responded to consistently, making it impossible to establish one denominator and percentages for each item.

STFM—Society of Teachers of Family Medicine

Meeting Frequency

Our results indicate that 48% of Balint groups meet only once a month (48%), and only 25% meet weekly and then only for 1 year. According to the standards of the American Balint Society, this frequency and duration of meetings is not sufficient. Protected time and space together with experienced leadership, including family physician role models, are necessary to create the trusting community within which professional growth can occur. For group work to progress from the examination of difficult cases to understanding how the individual group member's idiosyncratic or habitual way of dealing with specific kinds of patients or medical conditions, group cohesion is necessary. The American Balint Society has judged that sufficient group cohesion and trust probably can not be achieved when the group meets any less than twice a month for at least 2 years.[9]

What Is a Balint Group?

Finally, the perennial question, "Is a Balint group a support group?" must be addressed. The importance of this question was apparent from unsolicited comments that respondents provided when they returned the questionnaire. Representative comments include:

> [The groups] are better called personal awareness groups. They are case focused only a percentage of time although they have the title 'Balint.'

> We have a support group for interns—previous behavioral science faculty called it a 'Balint group,' but it is not.

> We have a 'monthly discussion group' focused on residents' personal and personal-clinical issues, but it is not a Balint group.

> I am writing to explain a few of my responses to your American Balint Society survey. First, I completed the survey for the groups we run, although we regard them as Balint-type groups rather than formal Balint groups. The faculty made a decision about a year and a half ago that a more informal style and somewhat more participative leadership met the needs of our residents better and was more compatible with the climate of our residency. Since we are not trying to run a true Balint group, I do not know if you wish to include these responses in your study.

These respondents' comments point to the confusing boundary between residency support groups and Balint groups. A survey of family practice residencies in 1992 found that 72% of all programs offered support groups for residents, as do an estimated 25% of internal medicine residencies. The focus of a support group is on the personal and emotional experience of professional life, helping group members grow in self-awareness and effectiveness. The goal is to provide

Table 6

Rating the Objectives of Balint Training in 1990 and 2000

	SURVEY YEAR			
	1990	*2000*	*2000*	
Number of groups	115	228	*A*	*B*
Understand the patient as a person	4.3*	4.5*	4.5*	4.5*
Provide support for residents	4.6	4.2	3.9	4.7+
Learn management strategies for specific psychiatric illnesses	2.4	2.4	2.3	2.4
Help physicians resolve professional role conflict	4.5	4.3	4.2	4.5++
Better understand psychiatric terminology	1.0	1.6	1.6	1.6
Acquire better understanding of psychotropic medications	1.0	1.4	1.5	1.4
Determine effect of patient's personality on illness	4.1	4.1	4.1	4.1
Determine effect of doctor's personality on illness	4.4	4.5	4.5	4.5
Learn counseling strategies for psychosocial illnesses	3.0	2.5	2.5	2.2
Learn family therapy	1.9	1.7	1.7	1.6
Determine role(s) assumed by doctor in managing a specific patient		4.4	4.4	4.5
Resolve personal conflict	4.0			
Understand specific psychiatric processes	2.3			

* Average score on a 5-point Likert scale, with 5 indicating the most-affirmative response: 1= not at all important; 5=very important

A—Leader has formal Balint leadership training
B—Leader has no formal Balint leadership training

\+ $P<.0001$
++$P<.05$