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The American Balint Society

Balint

Training

**A “how to” manual
in development.**

1. **Balint Groups - descriptions for future participants.**
2. **Groups for Practicing Physicians, Residents**
3. **Groups for Students**
4. **Balint Group leader roles and functions.**
5. **Including ground rules and rotation nuts and bolts**
6. **Contrasts of Balint Groups and Personal & Professional Development groups.**
7. **Balint Bibliographies.**

Dornfest in Santa Rosa, California:

Along with a memo reminding everyone of time and place, the following introductory description is provided for all new Balint group members in Santa Rosa.

Balint Training

Balint group training is a well developed method of understanding the doctor/patient relationship and learning the therapeutic possibilities of communicating skillfully with patients. Michael Balint, born in Budapest in 1896, was the son of a general practitioner. After completing psychoanalytic training in Berlin and Budapest, he emigrated to Scotland and moved to London after the War, where he worked at the Tavistock Clinic. There he and his wife, Enid, began the training-research seminars which today bear the eponym of "Balint groups." Balint was concerned with the psychological implications of general practice, and devising a method of training physicians to appreciate these implications and gain a usable understanding of the doctor/patient relationship. His method and insights are spelled out in, "The Doctor, His Patient and the Illness," A book that is said to have "changed the face of British Medicine."

Balint training steadily spread around the world but had little influence outside a few programs in the United States until recently. The format of Balint training is a weekly, usually hour long meeting of physicians, coordinated by a trained leader. The participants bring problem cases for discussion with their colleagues. Exploring these cases in depth is the principal method. On average, Balint groups meet for about 3 years.

The agenda for discussion at each meeting will be formed by the cases which the participants bring for discussion. These are regarded as problems when they impede the successful management of the patient and patient care or interfere with the degree of comfort the physician experiences in practice as a family physician.

Psychological problems in the patient.

Patient personality problems.

Problems in the doctor/patient relationship.

Problems in the family of the patient.

Problems in the doctor/colleague relationship.

The extended group discussions create an ongoing learning environment. This process provides physicians with the opportunity to repeatedly explore and validate their perceptions of the emotional factors that play a role in illness or interfere with their successful management of the illness; to become sensitized to the effects of emotional factors and personality types on the doctor/patient relationship; and to continuously define their role as family physicians in the context of exploring with colleagues in a variety of challenges.

The basic concept behind the need for this type of learning process is that all physicians have habitual responses to particular types of patients and problems. Further, every physician's practice has built within it certain recurring demands, dilemmas and vexations depending upon practice location, the physician's age and gender, and so on. Balint group discussion stimulates its members to examine their individual approaches and circumstances and explore alternative ways of responding. This method is not a doctor therapy group, nor is it a didactic seminar. The role of the group leader not to teach "content" or give advice, it is rather to stimulate the participants to gain a greater understanding of the doctor/patient relationship and to expand their repertoires for handling difficult situations.

Certain issues and clinical situations leading to an exploration of attitudes and the development of new skills include the following:

- Gaining a broadened diagnosis of certain "problem patients:" the dying patient, the thick chart patient, the seductive patient, the angry patient, the demanding patient, the dependent patient, the regressed patient, the highly anxious patient, the "game playing" patient, the non-complier, the potentially suicidal patient, the manipulative patient, the heavily somaticized patient, the patient who is also your banker or your neighbor, specially in a small town or rural practice.
- Handling difficulties in the doctor/doctor, doctor/consultant/patient, doctor/patient family, and doctor/patient/nurse practitioner or physician's assistant team
- Dealing with the perpetuation of the teacher/student relationship in

interactions with colleagues from subspecialty disciplines, a problem particular to family practice and hospital inpatient practice.

- Analyzing the pros and cons of reassurance.
- Recognizing the "apostolic function" of the family physician.
- Recognizing the child as the presenting symptom or complaint of the parents' problem.
- Recognizing the scapegoat patient, and being aware that the identified patient is not always the sickest member of the family.
- Learning a framework for understanding psychosomatic illness.
- Becoming familiar with a variety of useful concepts, such as the unorganized and organized phases of the somatization process.
- Learning how to listen, how to start and when to stop a counseling session, and when and when not to engage the patient in office counseling.
- Above all, the outcome of Balint training is a synthesis of cognitive and affective processing that leads the physician to a more precise, empathic and practical understanding of doctor/patient interactions and difficult patients. The physician learns to be more therapeutic in his or her relationship with patients while, equally importantly, learns a framework within which to view patients and practice that leads to less frustration, dissatisfaction with practice, and burnout.

The hallmark of this approach is that it does not deal with abstractions and resists idealizing both the patient and disease. The discussion does not turn on "What do you do?"

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 nonjudgemental 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.

Description of Medical Student Balint Group

Kathleen A. Zoppi, M.P.H. and Maria Rowe Gorosoh, M.D.

We have been conducting a Balint/professional development group for third year medical students who are doing their clerkship year at Henry Ford Hospital. These students, who are from the University of Michigan, selected Ford for required rotations in Internal Medicine, Pediatrics, Obstetrics/Gynecology, Psychiatry and Surgery (while students were previously not required to take a rotation in Family Practice, this next academic year they will begin a required Family Practice rotation). The Balint group consists of students who volunteer to participate and a physician and behavioral science educator who co-facilitate the group. The group meets weekly, unless the students have another commitment, for 1.5 hours after the day's work is over. Students are encouraged to present about patients or situations which they find interesting or difficult. The first year's group was lively bunch, focused on primary care and caring for patients. A theme of our discussions was the students' experiences of being in the ambiguous role of student caregivers - lots of responsibility without authority, difficulties of being seen as young (and therefore less credible) caregivers. The tension between idealism (which motivated many of the students to want to take care of patients) and the technical impersonal care they were sometimes taught to emulate was also a focal point for many

discussions. Students also worked hard on helping each other to look at their families and personal contributions to situations they found challenging or difficult. The group reported at the end of the year that the most useful aspect of these discussions were the opportunities to reflect on their own experiences in a safe environment, to clarify their career goals for selecting residencies, and the camaraderie they developed in the process.

Balint Group Seminar

An elegant curricular description of a Balint group, used Clive Brock in a residency based Balint group:

Goal:

To study the doctor-patient relationship (connections between doctor and patient).

Purpose:

- To understand the patient as a person.
- To determine the effect of the patient's personality on the illness and its management. (To view an illness in its specific context.)
- To support the professional transformation of its members from interns to family physicians through the types of cases presented.

Timeline:

- Two years.
- Two phases: Boundary exploration, Intragroup intimacy

Outcome:

Empathic understanding - awareness - that feelings generated when with patients reflect the patient's state of mind. Empathy has a biphasic structure:

- Subjective: Identification with another's state of mind
- Objective:

Intellectual or imaginative understanding of what has been identified with.

Enid Balint's comments about the absolutely perfect Balint group

Dear Frank,

It was good to get the American Balint Society Newsletter. What a lively lot you seem to be. I am glad to hear what you are doing and am only slightly alarmed when I read about an "absolutely perfect Balint Group" because one of the aims of Balint Groups is that there should not be such a thing! Each time we meet together we find out what is appropriate at that particular time with that particular group as we do with our patients. But I know that this is impossible and sometimes one is tempted in a group to say I wonder why you thought it was good to come in here or I wonder why you thought it was good to leave this? I am sure my anxieties about your knowing what an absolutely perfect Balint group is a kind of joke but at sometime we have to write down what we believe in and it is interesting to look at old scripts and find out what we thought in 1965 and what we think in 1990.

But congratulations and you have my warm good wishes,

Yours as ever,
Enid Balint

How the leader makes a diagnosis based on an assessment of the doctor-patient relationship.

Clive Brock at ABS 2 in Philadelphia

The skill the Balint-group leader uses and teaches to understand the doctor-patient relationship is empathy. A doctor-patient relationship is defined as the feelings and thoughts that flow between the two, connecting each to the other (transference and countertransference). Howard Stein recently wrote about two kinds of countertransferences. In the one kind, patients induce feelings in the doctor paralleling their own, e.g., the helplessness and hopelessness a doctor feels around a depressed patient. In the second kind of

countertransference, the doctor becomes the embodiment of an emotionally significant figure whom the patient's early life, e.g., the doctor may behave abusively towards a patient who was abused as a child.

The countertransference the presenter brings to the group reflect the patient's state of mind. They are communicated in the form of verbal and non-verbal cues. The leader must read these cues and direct the group's efforts towards understanding their significance.

Verbal cues are communicated as metaphors, slips of the tongue, second thoughts and omissions. As group leader I face great store in metaphors and regard these as the Freudian "royal road to the unconscious."

Non-verbal cues are experienced by the leader and participants as feelings, which in turn are communicated directly as verbal statements or indirectly through body language, ???? intonation and group process.

These verbal and non-verbal cues, arising as they do from the doctor-patient relationship, are the "clinical manifestations" of the case and are the signs the leader looks for to make a diagnosis: a diagnosis based on an assessment of the doctor-patient relationship.

BRIEF REVIEW OF LEADERSHIP FUNCTIONS AND ISSUES

From: **BALINT LEADERSHIP WORKSHOP**

WesternSTFM
San Diego - October 19, 1991
presented by Frank Domfest

OVERALL LEADERSHIP ROLE:

The leader, although designated, uses a shared leadership style to address both task and group maintenance. This means concurrently:

Recognizing the expertise and contributions which other group members bring from their clinical and general life experience; while taking by consent, responsibility for the tasks of :

- setting the frame for the group

- helping the group to continue on its vector through the material arising during case discussion.

The vector is directed toward increasing sensitivity to what occurs - both consciously and unconsciously - in the minds of the doctor and patient when they are together. Pursuit of this goal involves repeatedly re-focusing the group's energies towards this task by bringing a special set of skills to the group.

At the same time the designated leader shares with the other members the maintenance roles required to create an atmosphere supportive of the individuals during their exploration, constructive debate and critique of the doctor-patient relationship.

OVERALL GOAL FOR GROUP MEMBERS.

To develop a biphasic affective skill. The first phase is to identify with the patient. In the process, members learn to set aside their own intruding perceptions and emotional reactions at the root of their habitual responses or blind spots. The initial emotions and perceptions are conscious. Later, the group members begin to deal with notions, perceptions and emotions which were unconscious and begin to become available for examination. The second phase is learning to separate again after identifying with the patient. This is necessary in order to be freed up to evaluate the potential array of options for the patient.

TASK-ORIENTED ROLE:

- **Setting the frame**
Overall - To create an atmosphere which is free and friendly in which the group member can experiment and discover amongst other things that his/her behavior is often quite different from that intended. Of course, behavior speaks much louder than words. This is not easy or comfortable to begin to see one's mistakes, distortions, blind spots and limitations - so the group with the leader has to work on sufficient cohesion to support this process and allow each other to make these discoveries at a comfortable rate and in an understanding and accepting atmosphere. The atmosphere is one how everyone

doing this work has blind spots thus must allow the same understanding of the leader's fallibility.

Details

No notes, group frequency and duration, limit personal revelation - personal Vs professional ego, ask themselves questions rather than ask others.

- Model listening.
- Hold back until everyone had a chance to get involved.
- Model tolerating uncertainty. If you are not confused you will not be able to understand.
- **Maintaining the focus.**
- Occasional comments on group process that is interfering with group progress but almost never group interpretations.
- Representing the patient's feelings - if no one else does.
- Model tolerating silence, sadness, anger, being stuck.
- Resist temptation to treat the presented patient.
- Legitimizing the use of common sense rather than medical, psychiatric or psychological knowledge.

GROUP MAINTENANCE ROLE:

- **Maintaining the frame.**
Punctuality, confidentiality, protecting the presenter and members by reflecting questions, avoiding distractions, consulting about visitors and new members.
- Avoiding most group interpretations.
- Model "don't just do something - stand there".
- Encouraging playful speculating.
- Encouraging by being warm, friendly and responsive.
- Expressing group feelings - sensing feelings, moods, and relationships within the group - sharing them from time to time.
- Harmonizing - reconciling disagreements and getting people to explore their differences.
- Compromising - admitting error, offering to compromise one's own position.
- Gate-keeping - facilitating the participation of others.
- Avoid relationship issues outside the professional domain.

- Shared observing of data about the group life to better understand Overall direction. (With residents, helping to foster a group feeling of identity in a constantly changing group.)

SPECIAL SKILLS:

Recognize effects on one's own need to succeed and have group succeed. Trying too hard as in tennis and golf.

Active passivity (motor passivity) tuning a third ear into what is going on in group, kind of case presented; reaction of members to case, the presenter, leader and each other; do certain members behave in a certain way and what does that mean; listen to what is not said and why.

Make a quick diagnosis of the patient then not treat the patient but use the diagnosis to inform his work group. Will miss things in process but will allow leader to decide what its like for members to learn from the presentation.

Recognize Group Crisis. Especially the group singling out an individual/an individual isolating themselves - usually out of step with the group. Thus lacking the group's support to tolerate insight about the gulf that separates them.

Understand the time scale on which the group deal with issues. Understand the timing required for individuals or the group to deal with issues by allowing members to discover by making mistakes through habitual responses and seeing how others deal with the same situation better.

Recognition of parallel process. Understand parallel process and be able to use the understanding to e.g. model in the here and now of the group, by their own tolerance of group member's errors, how to tolerate listening to their own patients errors and distortions and allowing them to be themselves.

Allowing group members to be prima donnas or devil's advocates.

Exposing collusive avoidance of the leader's errors and shortcomings. The group should be able to critique the leader and have some fun at his expense without rejecting him or being hostile.

Recognize manifestations of resistance. Avoidance, denial, over-dependence on the leader, flight-fighting, isolation.

Recognize the stages of group development (Clive Brock):

This is a much more useful description of the developmental steps of the group than classical "forming, norming, storming, reforming and adjourning."

Phase 1: Exploring boundaries: omnipotence (helping everyone or no-one and identifying idealized expectations). The group presents ("pregnant nuns") demanding patients, patients who have quit on hope - narcotics, helplessness and non-compliance. Ends in appropriate humility and acknowledging professional role responsibilities and limitations.

Phase 2 Intra-Group intimacy. This is a springboard for examining personal specific blind spot areas. It requires increased group trust in presenting taboos like sex, money and death and where these interfere with patient care. The phase ends with dealing with loss, including the loss of the group. Hopefully, ends with clear understanding of how patient issues precipitate doctor's conflicts and being able more easily to disentangle their own issues from the patient's.

Recognize significant communications.

Skill at clarifying; summarizing; initiating or suggesting

Direction; tolerating uncertainty, silence, disagreement.

Opinion seeking; consensus-checking.

Balint Group Leader Functions

by John Salinsky, M.D.

1. Timekeeping - Deciding when to end one case and go on to the rest. Deciding when to end the session.
 - Discussion peters out 10 minutes before time. Should the session end or continue until designated ending time?
 - Discussion still in full flow at ending time - How long to let it go on?
 - Choose 2 cases at start or let one inspire another?
2. Case Selection - Making space for urgent cases, remember people who didn't get in with their case the previous week, deciding order of cases and number of case to be

presented. Occasionally ruffling our a totally unsuitable presentation (tactfully) e.g., someone else's patient, a bears case, a dead case. Asking for follow-ups.

3. Acting as a model of a good listener - for the presenting doctor. Being attentive, tolerant (if he goes on too long), empathetic.
4. Producing - Making space for quiet people to have their say (picking up what they say if none seem to have heard). Occasionally shutting up someone who persistently talks too much. Noticing any distress in group members, e.g. - a presenting doctor overwhelmed by own feelings about the patient or about him/herself. Limiting attacks on members it unwelcome probing of personal matters, e.g. - leader may say may not want to talk about that now - it's personal to him. Turn the question back to the questioner. Well what would you do? I think we are giving a hard time - lets give him/her a rest.
5. Focusing the discussion on the doctor patient relationship. Bringing the group back (like a sheepdog) when it strays.
6. Interpreting the group process To be used sparingly! e.g. - we seem to be trying to lose this patient because it makes us feel uncomfortable! Note use of 1st person plural "we" - not "you".
7. Representing the patient's feelings when no one else will, e.g. - "I guess if I was in this patient's shoes I would be feeling, etc."
8. Modeling moderation of silence, sadness, being stuck, etc.
9. Summarizing to get the group going again.
10. Reflecting questions. Discouraging too much interrogation of the presenter.
11. Encouraging speculation (sic) "play" activity. Free associations e.g. "What is your fantasy about the husband?"

**From Greg Troll in Salinas,
California:**

Rotations

In our program, we do Balint groups at noon on Fridays. This is theoretically "protected time"

anyway, as it is usually used for the noon conferences. In reality, certain rotations routinely ignore Balint and insist that the resident can get another to cover during the Balint group. It is a dynamic process that needs continuous negotiation and defense. An evening experiment never worked out.

Ground Rules

1. Balint group is for the exploration of the doctor patient relationship using interactive group process. The goal is the development of the reflective practitioner that can learn from the experience of patient and the nature of the healing relationship.
2. Balint group is a completely confidential forum. Material elicited during the group is not to be used for purposes of evaluation of trainees, or for QA process.
3. The role of the co-leaders is to facilitate the groups' exploration, to keep the group safe and focused on the case presented, and to help further the process of understanding and reflection. The co-leaders are not teachers in the didactic sense and should discourage being looked to as having the answer.
4. Balint group is not an encounter group and the object is not to break down the defenses of the presenter or other participants to make them see what the leader or other participants think is going on. Leaders should help the group support each other in increasing their understanding of their own practice. Although the primary goal of Balint group is not a "support group," the participants may derive some feeling of emotional support and encouragement from the process group.
5. Generally, the group functions by having a member present a patient whose case they find troubling, difficult or interesting. The group discusses the patient and the patient/doctor relationship. The discussion should remain focused on the patient and relationship in question. Balint groups are most effective when the group remains "grounded" in a real patient (or family) and a real doctor rather than discussing "this kind of case" or "issues."
6. The leader needs to keep the group safe by limiting disclosure of personal psychotherapeutic material except as really relevant to the patient doctor relationship, within the bounds of trust of the group.

LEADER MOVES

Shutting up

The leader's involvement in the group always has the potential of dis-empowering the group. An essential skill is to sit out the impulse to direct the group until it is clear what you wish to accomplish by your intervention.

Removing oneself from eye contact

This may be a positive move when the group seems to be looking for "the answer" or external confirmation of their own denial or prejudice.

Throwing the problem out to the group

This may help when the group attacks the presenter with questions or programs solving "advice." It also may help when the presenter seems to be drowning (or drowning) in their presentation.

Modeling reflection, uncertainty or spontaneous expression of reaction

This can have the effect of opening the group to different levels of perception, or freeing them to be more in touch with their own reflectiveness or feelings. It also can have a very directive impact on the group and may re-enforce the authority of the leader if overused.

Asking for reflection from the presenter

"How do you feel about..." "is this familiar to you..." If used well this may change the level of the presentation or group, and model grilling the presenter as the function of the group.

Reframing the problem for the group or presenter

There are many ways this can be done. The leader may point out the group processing the problem in parallel to the family or doctor-family system. The leader may shift labeling of the

situation (e.g. from the "hateful patient" to the "hateful patient doctor interaction"). By actively working in his/her own mind on different ways of understanding the situation, opportunities may present to change the paradigm used to understand. The danger of these kinds of interventions is that the leader will be expected to reframe in clever ways and thus "save the group" from their muddle. It is best used to help the group do their own reframing of the situation.

Being nice, accessible and flexible

Personally, I don't believe in the "pay no attention to the man behind the curtain" school of psychotherapy. If the group is to feel safe being reflective, fallible and exploratory, the co-leaders must be willing to be there as co-participants even as they focus in their role as facilitator. This sometimes may involve sharing the feelings of the presenter, the use of humor (especially the kind based on laughing at oneself) and being willing to experiment with the roles of the group and the co-leaders.

From Paul Scott in Pittsburgh, PA.

ROTATIONS:

At St. Margaret's, we have for many years run two simulation groups (1st year and "senior" i.e. - years 2 & 3) at the usual residency educational exercise time (11:30-1:00) every Tuesdays. We meet "religiously" every week from August through June, except for 2 weeks off at Christmas. I have been firm (and at times stubborn) about not permitting interruptions in continuity, either from without (requests for lectures on psychological issues) and feel that this preserves integrity of the exercise. After several years, the Tuesday noon time has become institutionalized as Balint day.

GROUND RULES:

In psychoanalytic therapy, i.e. - interpretation of dreams, there is a variety of stimuli to respond to. It is helpful when one feels lost to have a few "anchors" such as predominant affect, day residue, state of the transference, etc. Likewise, in leading a Balint group there are many stimuli and a road map or series of anchors can be helpful. Among these are:

1. Pre-meeting banter among members of the group - both themes and feeling tone.
2. Predominant affect of presenter, patient, group and group leader.
3. When in danger of becoming too focused on single member or his/her emotions or pairing with leader, the leader can:
 - (A) ask for group reactions, feelings.
 - (B) ask for more details of a specific case that reflects the presenter's problem.

DANGER SITUATIONS IN BALINT WORK

ECONOMY OF AGGRESSION

Aggression is an ever-present danger (and of course the fuel for much good work) in Balint groups. At times the level of tension within a group builds too high and may be destructive. It may reflect the tension of clinical work for members, their rage and helplessness personally and professionally, undue competitiveness among members or with leader. The leader must use this as a stimulus for self-examination and/or consultation, scrutinizing such issues as leader behavior in playing favorites, hating a certain member, competition with a member who is too smart, personal issues, own practice issues, program pressures, etc.

An over abundance of aggression can lead to such problems as scapegoating, dropouts, destructive modeling behavior, and of course dissolution of the group. In addition the above self-examination, it is helpful to emphasize the collegial - "we" - support for various points of view, etc. As last resort I rarely actively express disapproval in group of a destructive members comments. I know I have many more ideas and hope that others might enlarge upon the above "anchors" or "danger situations," too. Please send me a draft for the composite "How To" booklet, which might stimulate more ideas in turn.

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 group 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-disclosure, maintaining a friendly, welcoming atmosphere while judiciously resisting the group's 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 use up 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 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 going 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 let 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 thinking about that would be to miss the boat. The leader might then venture what is going on from the patient's perspective and push into an avoided territory, thus modeling a way of participating in the group.

The Balint group leader aims continuously to expand the horizon of each member about the meaning and possibilities of what transpires in the doctor/patient relationship encounter, without falling into a didactic role. Many facets of the

doctor/patient relationship benefit from being elucidated and the leader directs the focus to get that work done.

In the next issue we will take up another topic to explore the differences between Balint groups and Personal and Professional Development Groups. We invite your comments and your elaboration on the sort of distinctions we are attempting to draw.

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