Some Random Thoughts about Balint-group Pitfalls, Pratfalls and Pot-holes*

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Where I am from, Pittsburgh, Pennsylvania, the wide swings in winter weather, combined with a great deal of truck traffic and an overly thrifty highway department, combine to create in our roads VERY LARGE holes we call pot-holes. These are large enough and deep enough to cause one to a) lose a hubcap, b) blow a tire, c) bend an axle, d) end or delay one's trip. Some are so large they are dubbed 'tank traps'. When asked to comment on some of the pitfalls available to Balint-group training in the context of family practice residency, the image of these pot-holes kept emerging. I have been in almost all of them, witness my car!

Type A: System-issues that can sink a Balint-group:

1. Balint-groups are powerful tools for learning all kinds of 'lessons' about the doctor/patient relationship in the context of ongoing patient care. According to Michael Balint, the process, if conducted effectively, can result, over time, in a significant change in the physician's personality — at least in his/her approach to patients and a tolerance for difficult problems. However, it is a pitfall, I believe, to attempt to form a Balint-group in the midst of a residency (training programme) in which no one, or only the behavioural scientist, is interested and enthusiastic about the goals of patient care that Balint-groups promote. In other words, unless there is a mandate from the director and the faculty to have Balin-group training as an integral part of the residency, I think Balint-groups will find a way not to succeed:
   The group will be relegated to a scheduled time that is impossible or noxious to attend, such as evening or when no residents are free. It will be scheduled in a built-in conflict.
   It will be led and attended only by behavioural science faculty, instead of co-led by family practice faculty, and no faculty member will present a case.
   There will be no accountability for attendance and no policy to encourage attendance at Balint-groups; like at other conferences in the programme.
2. One must recruit equivalents to trainees in general practice, who are exposed to Balint-groups, understand what they are, and 'buy' Balint-groups as an important part of their training when choosing their residency.
3. Other parts of the residency programme (medicine, obstetrics, paediatrics, etc.) should be strong or residents may backlash against a strong weekly 'behavioural' processing of cases. If the precepting is not good, they will be seeking to augment it in Balint-group sessions. This point rests on the notion that problems in residency get projected into Balint-group discussions, in the affect presented, or the cases chosen. This is true in the group discussion itself, usually woven into the case, but especially in the 'idle' talk at the beginning. A strong programme in which residents can become secure in their medical knowledge creates an important balance for regular Balint-training and prevents pressures to pre-empt it with another type of case-discussion or support-group.
4. Balint-groups might be best evaluated by the residents and faculty without questioning the given nature of them in the residency. Feedback can be used to alert faculty Balint-group leaders to shifts in the process that are counterproductive. However, faculty leaders must also talk to each other after each session or after a series of sessions. At least some form of supervision should be available, because we too, as leaders, also project our own unfinished issues into the cases and into the group's process. We need to be aware of that to continue to be facilitators of the group.
5. Lack of trust in the programme, the faculty, director, residents, staff, leads to an atmosphere of low self-disclosure and posturing that is poison to Balint-group functioning. Conversely, Balint-groups that function well can keep an atmosphere of self-disclosure, genuineness, collaboration and trust alive in a programme.
6. Cancelling the group interrupts the continuity that is meant to run parallel to the continuity residents have with their patients. Be careful not to cancel or do so only under very unusual circumstances.
7. Residents must have some minimum opportunity for continuity with their patients. They must have office hours and follow their own patients. If this is not true in a given programme one is more likely to get cases like the dead patient or misbehaving attending (consultant) who spoke harshly to the resident on call, during Balint-sessions.

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Type B: Pitfalls Within the Group

1. Leaders who push the group process, push THE POINT and talk too much, represent a common pitfall (or pratfall). It is tempting to do, because it is exciting to have access to the participants' thought processes concerning crucial patient-care issues. However, when the group is doing well, meaning when they are talking and thinking and diverging, even if the leader does not like the content of what any of them is saying — leave it alone. Let them arrive at their own diverse conclusions. You may want to solicit different opinions and perceptions if someone is getting very dogmatic. However, it is best to busy yourself observing the process in the group so you are ready to know what is going on when the process bogs down.
2. When a group starts up or adds new members at the beginning of the residency year, residents (preferably) might well remind each other of the rules or conditions of the group to help get them started.
3. Case-presenters who talk too long holding off other members' involvement. Find a gentle way to get others into the discussion to escape this pitfall (or pot-hole).
4. Either group-members or leaders giving someone the third degree (asking them lots of questions) too long, or giving advice on how to handle the case is another common pitfall (maybe even a tank trap). There is an urge to 'fix' or 'do' that can overtake the discussion before there has been time to learn about the patient or to think. There is a fine line between the natural tendency to find out more about the case and trying to remote-control it. Reflecting on one's own reactions, or hearing and reflecting what the physician presenting the case is saying, or thinking about the patient, are all preferable to 'solving the case'.
5. A dilemma and potential pitfall lies in how to use observations of parallel processing dynamics. Sometimes reflecting it too soon, or even at all, interrupts the group's process and makes everyone self-conscious, in a non-functional way. Likewise, forcing someone to self-reveal is deadly to the Balint-group process and the trust it is based upon.
6. Over-directing the process, making the group dependent, rather than commenting or sharing observations in a constructive way, at an appropriate time is a common leader pitfall.
7. Finally, it is important to know, as best one can, when it is time to leave a particular case and go on. Perhaps now would be a good time.

Residential Balint-Group Leaders Intensive Workshop

13th to 16th October, 1993

The American Balint Society is holding a residential intensive workshop for Balint-group leaders, at Wild Dunes, an island resort near Charleston, South Carolina, from 13th - 16th October, 1993.

Participants will be able to analyse and discuss their own and each other's leadership skills as demonstrated by videotapes and audiotapes, as well as in live groups.

For further information and application forms, please call the co-ordinating secretary, Margaret Porcher in the Department of Family Medicine, Medical University of South Carolina, Charleston, SC, United States of America: 803 792 2410, or John Salinsky: 081 904 0911.
