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36 – The Balint Experience

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The Early Days of Balint

Balint groups are named after the psychoanalyst Michael Balint (1896-1970). In the late 1950s, Michael and his wife Enid began holding psychological training seminars for GPs in London. This work was first described in the book The Doctor, his Patient and the Illness (1957). There were no lectures and the doctors' education was based on case presentation and discussion in a small group of nine or ten with a psychoanalyst leader. To begin with, Balint encouraged the group members to hold 'long interviews' with their problem patients. This helped the doctors to concentrate on becoming good listeners. Subsequently the focus changed to studying the relationship between doctor and patient in the context of every day ordinary-length consultations. The groups met once a week for a number of years so that patients and their progress could be followed up. The continuity also enabled group members to feel at ease with other. Since those early days, Balint groups have spread across the world and in 20 countries there are national Balint Societies whose aim is to foster and develop the Balint approach.

Balint Groups Today: What Happens?

The group members and the leader sit in a circle and the leader (or one of the leaders if there are two) asks 'who has a case?' Someone volunteers to talk about a patient who has been on her mind. The problem may be that the patient has been emotionally disturbing or just difficult to understand or to engage in treatment. The group listens to the story without interrupting. When the presenter has finished, the leader invites the group to respond to what they have heard. Responses take various forms. There may be questions, advice to the doctor, emotional reactions induced by the patient's story and speculations about what else might be going on. The group leader will gently discourage too much interrogation of the presenter, as the aim is to get the group members themselves to work on the case. In a variation of the group process, the leader asks the presenter to 'sit back' i.e. to push his chair back a little and to remain silent for the next 20-30 minutes.

This effectively prevents the group from asking any more questions and throws them back on their own resources. The presenter is allowed to have her say and respond to what she has heard when she is invited to join in again later.

The Role of the Leaders

The leaders' first aim is to make the group a safe place, where confidentiality is observed and members feel free to talk about their feelings and their work (including their mistakes). The leaders will discourage unwanted and intrusive questions about

the presenting doctor's personal life and history. Personal anecdotes are sometimes volunteered and can be helpful. The leaders will allow this provided there is no pressure. The group is not a therapy group although its effects can be therapeutic.

The leaders' second aim is to keep the discussion focused on the doctor patient relationship. They may ask how the patient has made everyone feel. Do we feel angry or sad? Do we like the patient and want to help him? Or would we prefer to keep him at a distance? The group may be invited to consider how the patient is feeling or what sort of doctor he wants his doctor to be. A group that dislikes or fears the patient may be unwilling to engage and will try to 'escape' by talking about generalities: 'these patients are always untreatable' or recommending referral to an expert whom somebody knows. In this situation the leaders will try to bring the group back to the work, perhaps by representing the patient ('If I were this patient I would be feeling terribly alone and abandoned right now…')

If there are two leaders, they will be trying to work in sympathy, picking up cues from each other. One may steer the discussion while the other watches for people trying to get a word in. Often, the presenting doctor finds herself behaving like the patient, while the group members mirror her own reaction in the consultation.

Ending the Session

The session ends, like a therapy session, when time has run out. At least one leader will be keeping a discreet eye on the clock. There may be one or two presentations (including follow-ups) in a ninety-minute session. The leaders may ask for a follow up and thank everyone. They do not attempt to tie the loose ends or give a reassuring summary.

Benefits of Balint

What does participation in a Balint group do for a group member?

The first and most easily obtained benefit is to have a safe place where you can talk about interpersonal aspects of your work with your patients. The group will be sympathetic and they will all have been in similar situations themselves. This is a great relief and usually means that when a dreaded patient turns up again he or she will cause less anxiety. We believe that the Balint group experience helps to avoid professional 'burnout'. Are older Balint doctors still enjoying their work? Try asking them!

Secondly, the Balint group encourages doctor to see their patients as human beings who have a life and relationships outside the consulting room. They become more interesting to listen to and easier to help.

Thirdly, the group members may gradually reach a deeper level of understanding of their patients' feelings and their own. They may realise that certain patients or emotions may resonate with what is going on in their own inner and outer lives. This may be causing problems which the doctor can learn to avoid or even to turn to therapeutic advantage.

Take Home Messages

Taking part in a Balint group can help a doctor to:

- find a safe place to discuss doctor-patient issues
- see patients as human beings
- reach a deeper level of understanding of the feelings of both patient and doctor

Original Abstract

http://www.woncaeurope.org/content/25-balint-group-experience

References

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