Balint groups

An Australian perspective

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Balint groups are an important, internationally established method of training general practitioners in the psychological aspects of their work. Small groups of GPs meet regularly with a trained leader to discuss clinical material from their practices, with a focus on the doctor-patient relationship. This article explains the Balint group model and its benefits and describes what is known about Balint groups in Australia, including avenues for Balint group experience available to Australian GPs.

Balint groups were developed by psychiatrist Michael Balint – who worked with general practitioners in London in the 1950s – to meet the specific and unique needs of GPs. Since then, the Balint group method has continued, developed, and become internationally recognised, with an International Balint Federation and groups and societies in many countries.

Balint introduced the metaphor 'the drug, doctor' – the idea that the patient responds, not just to a pharmacological substance, but to the person of the doctor; the atmosphere the doctor generates and what the interaction means to both of them. The doctor, too, responds to the person of the patient, and this response can be a source both of difficulty in their interaction and also of important information about the patient. A Balint group explores such issues through detailed discussion of participants' accounts of their interactions with patients. Through participation, GPs learn to understand and skilfully utilise the doctor-patient relationship.

Literature about Balint groups includes descriptive accounts and reflections about their Balint group experience by participants and group leaders. Participants report increased ability to cope with difficult doctor- patient interactions, psychologically challenging situations and mental health issues; reduction in work related stress; and increased professional satisfaction.[1–6] Others report improvement in participant attitudes through Balint group participation.[7–11] A Swedish study[12] found that GPs in a Balint group felt more in control of their work situation and were less likely to think psychosomatic patients were a time consuming burden. A USA study[13] found that GP trainees in a Balint group showed gains in self reported psychological medicine skills, abilities, and confidence compared to those doing standard behavioural medicine training.

What happens in a Balint group?

Balint groups are generally ongoing with the same group of participants and leader over an open ended time period, often about 2 years. One or two group members present cases at each meeting and participants are encouraged to bring follow up reports of cases previously discussed. Any patient can be presented, not only patients with mental health diagnoses (*Table 1*). Participants are encouraged to present cases where they have experienced a strong reaction such as distress, frustration, surprise, difficulty, or uncertainty. The case is presented briefly, informally, without notes, emphasising the nature of the doctor-patient interaction and including the doctor's feelings, reactions and associations.

Group members may ask questions to clarify anything in the presentation and then the group discusses the material presented, with particular emphasis on the doctor-patient relationship. Group members are encouraged to speculate and take risks, without any pressure to be 'right'. The aim is to understand the situation in a deeper way, not to judge, advise or offer solutions.

A useful model is for the presenter to push back their chair and not participate in the initial discussion, giving participants an opportunity to listen and reflect, while the group works to make sense of the information. The presenter re-joins the discussion later. This approach helps protect the presenter from being interrogated, put on the spot or attacked, and helps the group to work hard with the inevitably incomplete material at hand. Diverse views about the dynamics of the case often emerge, reflecting the group members' varied personalities, life experiences, and blind spots.

Why Balint groups?

What is the point of an activity that doesn't offer solutions or advice? Contrary to some opinion, a Balint group isn't a self

indulgent opportunity to whinge about impossible patients, or 'navel gaze', nor is it a form of group therapy for doctors, nor does it aim to turn GPs into second rate psychiatrists or psychotherapists.

The benefits of Balint groups

Making the most of general practice as a unique discipline

Knowledge about diagnosis and treatment is necessary but not sufficient for good clinical practice. Because a Balint group is specifically focused on general practice, it takes seriously the uniqueness of the general practice setting which creates the particular challenges so familiar to GPs: symptoms which are not part of a recognised disease entity, complex mind-body interactions, difficult patients whom specialists can't help, time constraints, and patients who don't comply with treatment (see *Case study 1*). The Balint approach focuses on these types of difficulties rather than on specific diagnoses, seeking to understand the meaning of a patient's behaviour and symptoms. Without this understanding, there are many patients who are difficult to help. Conversely, there are many patients who, with this understanding, are ideally helped in a general practice context with its advantages of continuity of care, integration of the psychological and the physical, and the GP's knowledge of family and community.

Balint group participants therefore develop increasing respect for the specialty of general practice, realising how much it is an art as much as a science, and increasingly appreciate the opportunities general practice presents to engage with patients as people in a meaningful way.

Professional support

General practitioners typically have few opportunities to share their experiences with each other, particularly their feelings and the details of their interactions with patients. They often have little sense of how emotionally difficult and challenging their work can be and how much their colleagues may be facing similar difficulties (see *Case study 2*). Sharing these experiences in a Balint group provides tremendous mutual support.

Professional development

Balint groups do not teach specific treatment modalities, such as cognitive behavioural therapy and interpersonal psychotherapy, but directly address the doctor-patient relationship, the skillful use of which is crucially important in applying any treatment approach.

The focus on understanding rather than offering solutions contributes to growth in a GP's personality. The GP may become aware of their particular blind spots which create habitual and unhelpful ways of responding to particular types of patients or situations and become freer to respond more accurately to the needs of each patient; they may also become aware of their individual strengths. Their feelings and responses to patients become tools in understanding their patients better rather than sources of stress or unhelpful behaviours: the boring patients become interesting and the difficult patients become a welcome challenge! Participants often report finding their work more stimulating and enjoyable, and feel their participation has reduced work stress and prevented or reversed burnout. Balint groups are not therapy groups for doctors, although they may in fact be therapeutic; but the growth in participants' personalities occurs through a focus on their professional interactions and not through explicit disclosure of their personal lives.

Balint groups are unique

Although medical education has been profoundly influenced by the Balint approach, and some feel it has been superseded by other approaches and is of historical interest only, I believe it is of continued relevance today. No other approach to general practice education offers the same combination of respect for general practice as a unique discipline; focus on the doctor-patient relationship; applicability to a broad range of patients, doctors and treatment approaches; the opportunity to follow cases over a period of time; and the safety support, intimacy and opportunity for professional growth provided by an ongoing group setting with a trained leader.

Table 1. Common cases in Balint groups

Patients with psychosomatic symptoms	'Heartsink' patients
Patients with both physical and psychological problems	Multiple referrals
Difficulties in doctor-patient interaction	Demanding patients
Difficult situation involving third party such as family member, insurer, employer, social services	Child abuse
Patients with mental health problems	Drug seeking behaviour
Noncompliance	Life threatening illness
	Dying patients
	Bereavement

Balint group leadership

Balint group leader training generally involves some or all of the following: being a Balint group participant; working with an experienced leader as a co-leader; supervision; leadership workshops; and training in psychoanalysis, psychodynamic psychotherapy or group psychotherapy.

Balint groups in Australia

Balint groups in Australia have not been formally studied. Although there are Balint groups in Australia, informal enquiries suggest there are currently very few and, in contrast to countries such as the USA and Germany where Balint groups are widely used in vocational training,[14,15] this has been done rarely in Australia.

The reasons for this paucity are unclear. They might include: ignorance about Balint groups; difficulty in appreciating the value of an activity that is not didactic and solution focused; the belief that they have been superseded by other methods; the absence of more than a handful of trained leaders mainly located in urban centres; time and financial pressures on GPs; doctors' anxieties about the requirement for detailed self disclosure of their work; and finally, perhaps the culture of medicine and the personalities of doctors impact on their willingness to participate in Balint groups, which challenge a doctor's position of being the one with all the answers.

The Balint Society of Australia was

Case study 1

Denise presented a woman in her 60s from a non-English speaking background with a history of acute myocardial infarction with cardiac arrest. She presented frequently with 'terrible' pains varying in location, uncontrollable shaking and other somatic symptoms. Multiple specialists were involved, the patient presented with frequent crises, and Denise found it difficult to sort out her confusing symptoms and somehow felt that she was always stepping into a minefield. Denise thought the patient was very anxious, but the patient disagreed and insisted on physical explanations.

The group sympathised with Denise's difficulty in disentangling her patient's physical and emotional problems, exacerbated by her understandable anxiety about 'missing something'. They tried to understand why patient and doctor struggled to find common language and seemed somehow to be working at cross purposes. They speculated about possible cultural factors and helped Denise to reflect on why her patient might be so anxious. At a follow up presentation some weeks later, Denise realised that this patient, despite the involvement of multiple specialists, had been inadequately investigated from a cardiac point of view. The group speculated that somehow the anxiety and confusion this patient elicited had made it difficult for any of the patient's caregivers to think logically, and this problem had been exacerbated by the 'collusion of anonymity' created by the involvement of multiple specialists where no one doctor carried overall responsibility.

Case study 2

Harvey presented a patient dying of a malignancy, a 58 year old man with whom the doctor had had a long and gratifying relationship, having helped him make extensive lifestyle changes to cure his obesity. The patient's elderly father was also a patient of the practice, and the doctor was aware of the patient's adult daughter who had a serious mental illness. Harvey had been aware of the patient's poor prognosis since diagnosing an advanced cancer some 2 years previously, but it was only recently, after pursuing an unsuccessful 'alternative' treatment, that the patient had begun to face the reality that he was dying.

The group was very supportive of Harvey in having to bear the pain of his patient's incurable illness and imminent premature death, of having had to 'carry' this well before the patient was ready to acknowledge it, and of struggling to be sensitive, both to his patient's readiness to face a tragic reality and of his need to maintain hope. The group suggested the patient might have some 'unfinished business' to deal with regarding his adult daughter. Without being intrusive into the doctor's personal issues, the group identified the doctor's possible identification with a dying patient of a similar age to himself.

established in 2005. Its activities include: an email newsletter, scientific meetings and workshops, a website (www.balintaustralia.org), Balint leader professional development, and networking within Australia and overseas.

Overseas opportunities available to Australians include the International Balint Federation Congress every 2 years, the annual Oxford Balint weekend, and American Balint Society Leadership Intensive workshops twice per year.

Conclusion

Balint groups have the potential to address several important needs for Australian GPs:

- They provide professional development and support for GPs' central role in mental health care delivery as, in practice, the majority of cases presented in Balint groups are concerned with mental health issues
- Although their focus is not primarily doctors' health, they do seem to increase doctors' subjective sense of wellbeing and professional satisfaction and anecdotally prevent or reduce burnout
- They provide an educationally sound small group, active learning experience.

Conflict of interest: an earlier version of this article appeared in the newsletter of the Australian College of Psychological Medicine and extracts appear on the Balint Society of Australia website.

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