

***From Psychoanalytic Psychotherapy to Balint
Groups:***

What do leaders need to know?

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Balint groups were named after psychiatrist/psychoanalyst Michael Balint and his psychoanalyst wife Edith Balint who worked with London GPs starting in the 1950s (Balint, 1964). In a Balint group, a small group of practising GPs meets regularly with a trained leader to discuss their work, with a focus on the psychological aspects of general practice and particularly, the doctor-patient relationship.

In the early days of Balint groups, Balint group leaders were exclusively psychoanalysts. Nowadays, Balint group leaders come from a variety of professional backgrounds. In Britain, psychoanalysts have largely disappeared from Balint groups; in the U.S.A. they have had little to do with the Balint movement; whereas in some European countries, exposure to psychoanalysis is still expected of Balint group leaders (Salinsky, 2001).

In Australia, where Balint work has not been highly developed – the Balint Society of Australia (see website) was formed as recently as 2005 – we have interested a number of psychoanalysts and psychoanalytic psychotherapists in leading Balint groups. The majority of these people have no previous experience of either general practice nor of Balint work and many of them come from non-medical backgrounds. We have had to think about what they need to know and may need to learn in order to become effective Balint group leaders and this is the topic of my paper. In this paper, for the purposes of brevity, I will use the term psychotherapist to refer to someone with a background in either psychoanalysis or psychoanalytic psychotherapy, not because the two are identical, but because practitioners of both approaches adopt similar models of the mind and of the process of therapeutic change.

Balint group leaders need knowledge in three areas: psychological processes in both individuals and groups, general practice, and the Balint group model. Psychotherapists generally have an excellent understanding of psychological processes in individuals but they may or may not have any understanding of group processes,

about general practice or about Balint groups. In this paper, I discuss some of the things I think psychotherapists need to know about the nature of general practice, the Balint group model, and using psychoanalytic knowledge in the role of Balint group leader. I conclude with some case vignettes from Balint groups I have led.

What does a Balint group leader need to know about the nature of general practice?

Imagine yourself in a GP's surgery one Monday morning.

Your first patient is a dishevelled 21 year old heroin addict you've never met before. He describes a bizarre physical symptom not really pointing to any medical diagnosis. He aggressively requests a benzodiazepine prescription. You're glad you're not alone in the surgery.

Next, a 14 year old schoolgirl, who tells you with great embarrassment about a greenish vaginal discharge. She can barely get out the words, telling you she's had sex with two men in the last week. You feel like a cad asking her whether she's used contraception and you're not surprised she hasn't. You've recognized her mother in the waiting room. You gently ask whether her mother knows about any of this. She insists there is no way she can talk to her, and it's unthinkable that you do.

Your heart sinks when you see the file for your next patient, a 42 year old labourer with low back pain for five years. He'd been off work on workcover for six months, and has become addicted to pain-killing medication.

Next, comes an attractive 36 year old art teacher, whose neck pain you've successfully treated with a couple of counselling sessions, during which she confided some of her frustrations with her rather dour accountant husband. She's sent you a personally hand-painted Christmas card. You make sure the photograph of your wife and children is clearly in view on your desk.

Like these examples, which are all taken

from presentations by GPs at Balint groups, one third of general practice consultations are said to involve significant mental health issues, and seventy-five per cent of all consultations in Australia for mental health issues are with a GP. But neither making a psychiatric diagnosis and treating it according to the textbooks, nor referring the patient off to a mental health professional are likely to be of much immediate use in these encounters.

Here is a list, which is by no means complete, of some of the characteristics of general practice Balint leaders need to know:

GPs' day to day work involves numerous contacts with many people and lots of paperwork.

Most GPs are responsible for a large number of patients.

GPs' relationships with their patients are often long-lasting and may terminate only with the death of the GP or the patient, or when one party decides to sever the relationship.

GPs often treat their patients' families and friends.

GPs often have multiple roles in their communities, which may entail their having relationships with their patients other than the doctor-patient relationship, such as friendships or other professional relationships.

GPs are faced with sometimes confusing mixtures of physical and psychological problems as well as the complex interrelationship between mind and body.

GPs often take on varying roles at different times with their patients. GPs generally have huge constraints on the time they can spend with patients.

GPs' relationships with patients are often complicated by the involvement of third parties, such as employers, insurers, colleagues and relatives. The bulk of treatment for mental disorders in the community is done by GPs.

GPs must manage a great deal of uncertainty.

GPs are confronted with illness and suffering, much of which they cannot cure or alleviate.

GPs carry ongoing responsibility (whether or not they feel they can help their patient).

GPs' patients are usually unreferred.

General practice is unpredictable. Psychotherapists, who may not be medically trained, need to acquire not only factual knowledge, but a feeling for what it is like to be a GP at the coal-face.

What do psychotherapists need to know about Balint groups?

Leaders need to know what kinds of patients should be presented, how they are presented, the kind of discussion that is facilitated, the tasks of the group and the leader's role.

In particular, the GPs present and discuss cases from their own practices, both new cases and follow-ups. Any patient can be presented, not only patients with mental health diagnoses. Members are encouraged to present cases where they have experienced a strong emotional reaction. Typical examples include frustration, sadness, surprise, puzzlement, impotence, anger, dislike, confusion, uncertainty, embarrassment, resentment, being intruded on, being unfairly blamed and feeling overwhelmed.

The doctor is invited to tell the story of themselves and the patient, briefly, informally, without notes. The doctor is asked to try and convey the atmosphere in the consulting room – what is the patient like, what is it like being with him or her, how do YOU feel? Group members may ask questions to clarify anything in the story and then the group discusses the material presented.

The group's task is to elucidate the emotional aspects of the doctor-patient relationship – to empathize with both the doctor's and the patient's experience and to reflect on their interaction - and to use this deeper understanding to explore what the patient needs from the doctor. The 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. Because group members bring

their varied personalities, life experiences and blind spots to the discussion, they will respond in diverse ways to the material presented.

The leader's tasks include keeping the group focused on the task, keeping the group safe, protecting participants from intrusiveness, criticism or undue dominance by any group member, discouraging advice-giving, and guiding the group towards deeper understanding. There is no attempt to find a solution to the case. There is often a sense of incompleteness: things left up in the air and the leader needs to help the group bear this uncertainty.

Learning how to apply their psychotherapy skills in the role of Balint group leader

This is a third aspect of learning for the psychotherapist, closely related to understanding the Balint group model. There is much that psychotherapy and Balint groups have in common. For example:

1. The focus is on psychological issues, both within the patient and particularly between patient and doctor. This is very different from the emphasis in much GP education about psychological issues which focuses on mental health diagnostic categories (such as depression or anxiety) and treatment modalities (such as medication and CBT). The Balint group draws on the psychotherapist's familiarity with the intrapsychic domain to explore the intrapsychic world of the patient and what this evokes in the doctor (Balint, 1993, p. 23).

2. Just as a psychoanalyst might think about transference, the group discussion throws light on how the patient's unconscious, internal world colours their experience of the doctor. And just as the psychoanalyst might reflect about counter-transference, the group might help clarify to what extent the doctor is bringing a personal issue to the encounter with the patient, and to what extent is he or she carrying a projection from the patient. In a Balint group, psychoanalytic technical language isn't used. Instead, the leader

might explore these questions by asking: What is the atmosphere in the consulting room? What is it like to be this patient? How would each of us feel confronted by this patient? Can our feelings tell us anything about this patient's experience?

3. The psychotherapist brings to the Balint group his or her familiarity with the concept of unconscious processes, of symbolic communication and of intrapsychic contradictions. The group learns that there is value in taking a wider view than the presenting symptom (Balint, 1993, p. 35).

4. In a Balint group, doctors gradually develop the capacity to identify and reflect about their feelings and responses to patients. It thus becomes a container for these responses, and the doctor is less likely to enact them in an unhelpful way. Over time, the doctor develops the capacity to do this for him or herself. I think there are parallels here to the development of this capacity in a patient in psychoanalytic treatment.

5. The task of the Balint group, as in psychotherapy, is not to be prescriptive. The aim is deeper understanding which allows the possibility of change. Doctors in a Balint group will often present similar cases over a period of time, and report changes in their approach to that particular difficulty.

Psychotherapists need to understand how unsettling this non-prescriptiveness can be for GPs. Medical education is quintessentially concerned with doing and it can be a great shock to be asked specifically to focus not on giving advice and figuring out what to do, but on understanding.

6. In both psychoanalytic therapy and Balint groups, there is a clear frame within there is freedom. The Balint group frame includes the regular meeting times, and continuity with participants and leader, and the work of the group which focuses on the doctor-patient relationship. Within this frame, what the doctors do is a form of free association, as in psychotherapy.

7. Balint groups may be psychotherapeutic for participants, despite

not being therapy. The GP may become aware of their particular blind spots which create habitual and unhelpful ways of responding to particular sorts of patients or situations and become freer to respond more accurately to the needs of each patient. Their feelings and responses to patients become tools in understanding their patients better, rather than sources of stress or unhelpful behaviours. Personal growth in the doctor is a difficult topic to illustrate because of confidentiality, but participants do commonly report significant improvements in work satisfaction, and demonstrate increased confidence, capacity to tolerate anxiety and uncertainty, and ownership and more appropriate use of their aggressive impulses.

8. As in psychoanalysis, the learning Balint groups aim to facilitate in participants is not the acquisition of intellectual knowledge, but knowledge about themselves and their patients as people, particularly with respect to their felt experience: a growth in the capacity to observe, together with the interrelated capacity to bear what one observes, in self and other. The rationale for this is that much of the healing in the patient will take place through recognition and acceptance of the distress which the patient offers and which is felt by the doctor (Balint, 1993, p. 23).

9. As in psychoanalysis, participants learn to take emotions seriously, to reflect about how emotions influence reason (Lichtenstein and Lustig, 2006) and to think about themselves as participant-observers, who necessarily influence and are influenced by what they observe.

However, a Balint group has many important differences from psychoanalytic therapy, including:

There are clear boundaries for what can be talked about – the focus is clearly on participants' interactions with patients and not on their personal lives.

The leader generally does not make interpretations about the doctor-patient relationship being presented; nor about interactions within the group; nor about individual doctors, although the leaders'

hypotheses about any of these issues may well guide their interventions.

Very closely related is the importance in a Balint group of facilitating the group doing the work – as opposed to becoming a guru who can see what's going on better than the group participants. This is important, not only because people learn better when they discover something for themselves than when they are told it, but because it resonates with the position we want to encourage GPs to take – that of experts in psychosomatic medicine who can carry responsibility for their own patients (Balint, 1964, p. 289).

The idea is to teach the GPs an approach rather than the conclusions the leader might reach themselves. This is done by teaching participants to listen and observe more closely – to hear what the patient is telling them – not by doing it for them. Tempting as it may be, the leader's task is not to provide insight into the psychological causes of a patient's illness, nor the techniques needed to manage them (Balint, 1993, p. 44). Sometimes the leader helps the group by being able to model the capacity to bear not understanding or to be wrong. Leaders should encourage a state of mind where the doctors can hold back and not rush in too quickly to find explanations, working to counteract the professional tendency to observe only what we already understand (Balint, 1993, p. 48).

The group experience

Psychotherapists may not have experience working with groups. They will need to consider how to keep the presenter and the other group members safe and how to create a space where difference and diversity can be tolerated and worked with. They need to learn to observe the process as well as the content of the group, and they may well discover that attention to group process will deepen their understanding of the dynamics of the doctor-patient interaction being discussed.

In summary, the challenges which may be faced by psychotherapists becoming Balint group leaders include:

1. Learning what general practice is like.
2. Learning about Balint groups.
3. Avoiding turning the group into a supervision group for psychotherapy – or an exercise in psychiatric diagnosis and treatment – keeping the focus on the GP as a GP.
4. Not allowing the group to become group psychotherapy.
5. Learning to facilitate the group doing the work.
6. Learning about group process.

Case vignettes

I conclude by giving some case vignettes from Balint groups I lead, in order to illustrate the kind of work that can be done in a Balint group.

Case presented in GP group #1

Denise told us about a 60 year old woman from a non-English speaking background. Two years ago, she had experienced an acute myocardial infarction with cardiac arrest. She presented frequently with ‘terrible’ pains in many parts of her body, uncontrollable shaking and numerous other somatic symptoms. Multiple specialists were involved. There were frequent crises. Denise found it difficult to sort out the confusing symptoms and somehow felt that she was always stepping into a minefield. Denise thought the patient was anxious, but the patient disagreed and insisted on purely physical explanations.

The group readily sympathized with Denise’s difficulty in disentangling her patient’s physical and emotional problems, exacerbated by her understandable anxiety about ‘missing something’. They reflected on why patient and doctor struggled to find common language, and seemed somehow to be working at cross purposes. They speculated about possible cultural factors – perhaps in this patient’s ethnic group, feelings were generally expressed as bodily symptoms. They imagined what it would be like to have had one’s heart stop, and they wondered whether there were any other life experiences contributing to this patient’s intense anxiety.

When Denise reported back to the group

some weeks later, she had been surprised to realize that this patient, despite the involvement of multiple specialists, had actually had inadequate cardiac investigation. 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 – the involvement of multiple specialists where no one doctor carried overall responsibility.

This case illustrates many issues. Firstly, it is a typical example of the often confusing psychosomatic presentations GPs struggle with. Secondly, we could speculate that the patient has been projecting anxiety into the doctor, indeed into all the doctors. The group recognizes this and this allows them to reflect more about the patient’s experience and the possible sources of her anxiety. At the follow-up, the doctor is clearly freer to think more rationally about her patient and to carry responsibility for the patient more effectively. Thirdly, the case illustrates the unique role an adequately supported GP can play in assuming responsibility, where there might be unconscious pressure coming from the patient for each doctor involved to pass the buck. Fourthly, the case is a good example of how the prescriptive approaches to mental health issues mandated in most GP education nowadays would not be helpful; this patient’s anxiety cannot be addressed as a discrete mental health issue, without exploring the impact of the anxiety on the doctor, and freeing the doctor to explore both the medical and the psychological aspects of the case.

Case presented in GP group #2

Mary told us about a patient dying of a malignancy, a 58 year old woman with whom the doctor had had a long and gratifying relationship. In the past, Mary had supported the patient in making extensive lifestyle changes to cure her obesity. The patient’s elderly father was also a patient of the practice, and Denise was aware of the patient’s adult son who had a serious mental illness. Mary had been aware of the patient’s poor prognosis

since diagnosing an advanced cancer some two years previously, but it was only recently, after pursuing an unsuccessful alternative treatment, that the patient had begun to face the reality that she was dying. Denise was upset that this patient had done everything she could to improve her health and yet was now seriously ill.

The group was very supportive of Mary in having to bear the pain of her 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 her patient's readiness to face a tragic reality and of her need to maintain hope. The group suggested the patient might have some unfinished business to deal with regarding her adult son. 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 herself.

This GP is deeply and effectively emotionally engaged with her patient. The group helps her to name the emotional work she is doing in sharing the patient's journey through incurable illness, thus supporting this important work. The group also alerts the doctor to the possible personal significance of this work, without explicitly discussing her personal issues, illustrating the boundary between Balint work and personal psychotherapy.

GPs typically have few opportunities to share such experiences with each other. GP culture generally does not include a space for discussing their feelings and the details of their interactions with individual 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. Sharing these experiences in the group provides tremendous mutual support.

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