INT'L. J. PSYCHIATRY IN MEDICINE, Vol. 45(4) 401-411, 2013

BALINT GROUPS: THE NUTS AND BOLTS OF MAKING BETTER DOCTORS

DAVID MAHONEY, MD, MBE

VANESSA DIAZ, MD, MS

CAROLYN THIEDKE, MD

KIM MALLIN, MD

CLIVE BROCK, MB, CHB

JOHN FREEDY, MD, PHD

ALAN JOHNSON, PHD

Medical University of South Carolina

ABSTRACT

Balint Group seminars were developed by Michael and Enid Balint based on the application of psychological principles in a group setting for the purpose of developing an improved understanding of the doctor-patient relationship. This article focuses on the development and application of the Balint method to the training of resident physicians (particularly Family Physicians) within the United States. An effort is made to describe the practicalities of resident physician Balint training (e.g., size, frequency, duration of such groups), conceptual underpinnings (e.g., biphasic nature of patient identification, disease versus illness concept, transference/counter-transference, over-identification, under-identification, biphasic nature of physician empathy), and pedagogic goals (mastering empathic skills inherent in being a good doctor) of residency-based Balint groups. In aggregate, this article provides a useful framework for behavioral science educators interested in applying the Balint seminar method to resident physician training. The authors encourage both the continued study and educational application of the Balint seminar method in the training of physicians both within and outside of the United States.

(*Int'l. J. Psychiatry in Medicine* 2013;45:401-411)

Key Words: Balint Group, psychological principle, doctor-patient relationship

© 2013, Baywood Publishing Co., Inc.
doi: http://dx.doi.org/10.2190/PM.45.4.j
http://baywood.com

OVERVIEW

Michael and Enid Balint were psychoanalysts who, in the 1950s, explored new seminar methods of group procedure in which physicians could develop insights from specific troubling doctor-patient relationships and thereby improve their relational skills. These gatherings marked the origins of what we today refer to as Balint training. This training is consistent with educational theory and experiential learning by deriving meaning from direct experience. The training is meant to encourage good doctors to excel [1]. The Balint seminar should not be considered a method of turning mediocre doctors into good ones, or inducing good practitioners to pursue psychotherapy practice.

Balint groups have been used by a variety of participants, such as resident physicians, medical students, and hospice staff, and in Continuing Medical Education (CME) [2-6]. In the United States, Balint training occurs in residency programs associated with Family Medicine, Psychiatry, Pediatrics, Obstetrics and Gynecology, and Internal Medicine. About half of Family Medicine residency programs in the United States conduct Balint groups as part of their behavioral science curriculum or to meet residency requirements for providing resident support. This prevalence has been relatively stable over the last decade, with 48% participating in 2000 compared with 54% in 2011 [7, 8]. Despite the widespread availability of Balint groups for residency training purposes, there is much variety in their procedures. A total of 40 leaders are credentialed by the American Balint Society (ABS; www.americanbalintsociety.org). The ABS promotes the growth of Balint seminars through leadership training and a credentialing process.

DESCRIPTION OF GROUPS

The purpose of Balint training is to study the doctor-patient relationship in a group setting with the expectation that the therapeutic potential of relationships can be revealed and explored through the cultivation of empathy. Groups have between 4 and 10 members, and meet every 1 to 4 weeks for 1 to 3 years. In the group seminar, a resident presents a “troubling patient” from memory while the group listens without interruption until the presentation is complete. No particular resident is assigned to present in a given week; rather, the process occurs spontaneously. The goal of the presentation is to understand the issue from both the patient’s and doctor’s perspectives rather than find specific solutions—clinical or otherwise—to the problem at hand. The presentation can last up to 10 minutes, after which time group members are free to ask clarifying questions. When all questions are exhausted, the group picks up the case and is invited to imagine themselves in the roles of the doctor and the patient. At this time, some Balint groups have the presenter “push back” from the group and refrain from any further input until the leader feels that it is an appropriate time for the presenter to rejoin

the group. This process is analogous to clinical reasoning, and is meant to illuminate the "trouble" in that particular doctor-patient interaction. In our view, the presentation is analogous to the history and the case discussion is analogous to the physical examination. Time is spent on framing behaviors seen in that specific visit, with that resident physician and patient; the resident may experience an entirely different set of behaviors with the same patient at a subsequent visit.

The leader's role is to identify clues in the presentation that are manifestations of the presenter's identification with the patient. It is this unconscious connection which troubles the presenter. The leader ensures the safety and progress of each group member, focuses on the presenter's professional self, and discourages delving into private psychological matters. The leader is also meant to discourage advice-giving at the expense of empathy. This is not meant to be a support group; there is no encouragement for group members to defend themselves against uncomfortable thoughts or feelings, as a certain amount of anxiety is required to promote professional growth in the presenter.

PURPOSE OF GROUPS

Balint work is based on understanding and identification. As Enid Balint explains, the identification process must have a biphasic structure: "[O]nce an observer has identified himself with someone or something, he will find it difficult to feel objectively about that person or thing again. But he must first identify, and then he must withdraw from that identification and become an objective, professional observer" [1]. She goes on to explain that the doctor's role is to "hold onto the feelings which a patient has put into him, and with which for a short time he totally identifies with, but which he is then able to distance himself from" [1]. We understand this to be the empathic process.

Understanding the concepts of transference and countertransference is vital to making a good doctor better. Transference can be thought of as perceptions, feelings, or expectations that the patient unconsciously ascribes to the physician, oftentimes evolved from unresolved or unsatisfactory childhood relationships.

Countertransference, a normal and unconscious occurrence as well, involves the physician's reactions, behaviors, thoughts, and feelings toward the patient as a result of unresolved past relationships. We often think of these associations as "blind spots" precisely because we cannot see them; our behavior alters before we recognize what has transpired.

In order to remain in the role of authentic provider, the doctor must effectively manage transference and countertransference in his relationships with patients. It is critical that he be delicately aware of these roadblocks and skillfully avoids them through employment of the empathic response. Disease (a pathophysiological condition) itself can be relatively easy to manage. Illness (the experience of a specific person with a disease and the pathophysiological condition), however, is not. We constantly struggle with over- and under-identification,

striving to avoid stepping into the role of rescuer or abuser while maintaining a sense of authentic empathy. The behavior of Balint group members can represent the various transference-countertransference issues in the context of the presented doctor-patient relationship. When the Balint leader asks "What sort of doctor does this patient need?" the question really translates to "How can this doctor most effectively manage transference and countertransference to encourage a more therapeutic encounter with this patient?"

In clinical practice, empathy is an acquired skill used by physicians to better understand the doctor-patient relationship and the patient's story. For a patient, the physician's understanding often fosters trust, an essential component of a therapeutic relationship. Brock et al., borrowing from Enid Balint, describe a multilevel architecture to mastering empathy [9]. Empathy has a biphasic structure: empathic understanding and empathic response. Empathic understanding of thoughts and feelings passing from a patient to a physician usually occur naturally, provided the clinician has the capacity. This capacity is not a learned behavior; it must be hard-wired. An effective empathic response, however, can be acquired through training. The empathic process is hindered when the physician is stuck between understanding and responsiveness. This state of "being stuck" may be a manifestation of the physician's defensiveness or a lack of awareness of the transference and countertransference that is occurring in the interaction.

Another pitfall for the presenting resident physician is to find himself engaging in a particularly heroic role when relating to "troubling" patients. This reflects a resident's behavior when "stuck" in a role that is driven largely by unrealistic professional expectations [11]. Without reflecting, the resident assumes the role of heroic rescuer and soon realizes that the disease has become more important than the illness; that the patient is, in fact, an onlooker at best, and at worst an annoying hindrance to the resident physician's well-conceived, scientifically driven treatment plan [12]. The resident naturally falls into this role to rescue or to protect the patient, the family, or himself from a distressing medical predicament.

As a rule, Balint group cases often reflect the presenting resident's trouble staying in the role of physician and fulfilling those role expectations [13]. In his "authentic" professional role, the physician is expected to determine the reason for the visit and to implement a management plan based on best practices. As noted above, the physician may find himself deflected into the "inauthentic" role of nurturer or rescuer (a form of over-identification). Alternatively, the physician may be distracted by influences from the family, nurses, colleagues, or the persona of the patient causing objective assessments and management of the illness to be lost in an accepted social prejudice (a form of under-identification). Thus, it has been argued that staying in the role of physician in the face of deflections (over-identification) and distractions (under-identification) is the professional responsibility of a competent physician. The acquisition of this skill lies at the essence of Balint training in making better doctors [13]. It is, in fact, at the very core of medical professionalism. Empathy can be learned by recognizing

the biphasic nature implicit to its very definition. Once the patient appears in a new light, both the presenting resident and the group feel liberated to imagine being a different kind of provider to the patient with the therapeutic implications that accompany this liberation.

OUTCOMES

Utilizing interviews and questionnaires, outcomes research of Balint groups has been done with medical students, residents in training, and practicing physicians. In general, these studies have reported favorable outcomes as a result of participation in a Balint group (Table 1).

The most frequently reported benefit is an improvement in self-concept as a physician [14, 16, 17, 21, 24]. This is variously reported as improvement in confidence, comfort, professional self-esteem, or competence in the patient encounter. Other improvements related to changes in relationship with patients, such as an increase in the ability to deal with emotional patients [15], or in the ability to be psychotherapeutic with patients [20]. In addition, it has been reported that physicians who regularly attend Balint groups found psychosomatic patients less often a burden, were less resentful toward patients [5], and felt they were more patient centered [20]. These were somewhat predictable outcomes of Balint training, and yet other expected outcomes were not found; for example, there was no improvement in empathy scores [14, 20], no change in the perceived stress in the environment, no lessening of discomfort with psychological issues [15], and an actual increase in levels of self-reported burnout was shown in one study [21].

Additional benefits were reported that have real implications for a healthcare system [23]. Physicians in the United Kingdom who went through an intensive Balint-type experience ordered fewer tests, prescribed fewer medications, and had higher patient satisfaction scores, as well as reported improved scores on making appropriate treatment decisions [20].

The Balint method appears to have some efficacy in helping physicians deal with existential issues [14] by reporting that family physicians who had participated in Balint as residents were happier with their choice of specialty than residents who were non-attenders. Others said Balint helped them "endure their job" and "find joy and challenge in their relationship with their patients."

DISCUSSION

The goal of Balint is to make good care better by providing skills that are necessary to improve patient-physician relationships. Patient-physician communication involves not only the knowledge of the right questions to ask while interviewing, but also the use of relational skills to develop and maintain an appropriate relationship with the patient. As Michael Balint stated, providers must undergo "a considerable though limited change in personality" to interact

Table 1. Summary of Findings

Name of lead author	No. and type of learner	Intervention	Study type	Positive findings	Negative findings
1. Cataldo [14]	182 practicing family physicians	Residency-based Balint training	Survey, Jefferson Scale of Physician Empathy	Satisfaction with choice of specialty	No difference in empathy, financial satisfaction, overall work satisfaction
2. Sekeres et al. [15]	28 heme oncology fellows	Residency-based Balint training	"Attitude" questionnaires	More positive attitudes; improved view of self as a physician; slight improvement in comfort dealing with emotional patients	No change in stress of work environment; no change in discomfort with psychological issues
3. Turner & Malm [16]	14 family medicine residents	Comparison of traditional behavioral science curriculum vs. Balint groups	Psychological Medicine Inventory	Improvement in self-reported psychological medical skills; improved confidence	Not reported
4. Musham & Brock [17]	Family medicine residents	Residency- based Balint groups	MBTI, personal interviews	Improved effectiveness as family physicians particularly with difficult patients; frequent attenders have higher MBTI scores in the intuitive dimension	Nonattenders did not participate because of emotional or psychological variables
5. Graham et al. [18]	17 psychiatry residents and counselors	Residency- based "Balint style" discussion group	In-depth interviews	Residents felt they benefited from "psychological learning process"	None reported

6. Bacal [19]	24 practicing physicians	Balint group participation for 2.5-5 years	Interviews with participants and with non-participant controls	Doctor recognizes limitations, uses consultation appropriately, and has minimal interference from own psychopathology	No change in empathy
7. Ghetti et al. [20]	17 Ob-gyn residents	Residency-based Balint groups	Psychological Medical Inventory, Maslach Burnout Inventory, Jefferson Scale of Physician Empathy	Lowering of burnout scores in some dimensions; improved ability to use consultation; improved ability to make appropriate treatment decision; improved ability to be psychologically therapeutic with patients	Increase in self-reported burnout
8. Margalit et al. [21]	102 practicing primary care physicians	Comparison of didactic CME course vs. interactive Balint-like discussion groups	Structured questionnaires	Improved professional self-esteem	None reported
9. Kjeldman et al. [22]	41 practicing GPs; those who participated in Balint and those who had not	Community-based Balint groups	Questionnaire	Balint participants were more patient centered	None reported
10. Margalit et al. [23]	102 practicing GPs attending a CME workshop	Comparison of didactic CME vs. interactive Balint-like discussion groups	Videotaped encounters before and after intervention	GP's who attended the Balint intervention ordered fewer medications and labs; had higher patient satisfaction scores	None reported
11. Kjeldman & Holmström [24]	9 practicing GPs who had long-term attendance in Balint group	Community-based Balint groups	Interview	Increased competence in patient encounters; felt better able to endure their job; felt joy and challenge in relating to their patients	None reported

12. Kjeldman et al. [5]	41 practicing physicians who were Balint group participants	Community-based Balint groups	Questionnaire	Reported better control of their work situation; thought less often that patients should not have come in for consultation; less often viewed psychosomatic patients as a burden; decreased inclination to refer patients for unnecessary tests	None reported
13. Torppa et al. [2]	15 medical students	Student Balint groups	Evaluation of field notes	Topics discussed included feelings related to patients, one's role as a doctor, future identity	None reported

competently with patients [25]. In functional terms, competent providers engage in work commensurate with their clinical limitations, appropriately obtaining consultations as needed, and allow minimal interference from their own "blind spots" on their work [19]. These conditions are necessary, since providers cannot perform the tasks needed for accurate diagnosis and treatment of disease if they are not authentically in the professional role; it is necessary for a competent doctor to manage transferences and countertransferences. Balint seminars seek to help providers manage these difficult situations in order to remain in role, thereby improving care. However, these skills do not supplant the need for a sound foundation of medical knowledge, as they must be added to a provider's basic medical skills to be successful.

Due to the goals of Balint groups, it has been difficult to access outcomes associated with their use. For instance, some studies, such as those evaluating empathy, may not find an effect because they are looking at knowledge and attitudes around empathy, as opposed to assessing the skill with which it is used during patient encounters. Ultimately, the methods to best assess skills associated with empathy and relationship-building are still undetermined.

Finally, Balint groups aim to help providers gain insight into what the relationships with their patients may signify. It may not always be clear how to best use these insights. Although some may propose that these insights should be shared with the patient, it may be more prudent for providers to keep the insight to themselves and instead try to use their actions during the visits to become the change they would encourage in their patients (to role-model an attitudinal balance between self-acceptance and personal accountability). For Balint groups to be deemed successful they do not need to lead to changes in patient outcomes or patient care. Instead, Balint groups aim to help providers recognize their blind spots and transferences, helping them to better understand their reactions to difficult patients. It is this self-illumination that makes them better doctors, enabling them to be more authentic in the doctor's role.

REFERENCES

1. Balint E. The history of training and research in Balint-groups. *Psychoanalytic Psychotherapy* 1985;1(2):1-9.
2. Torppa MA, Makkonen E, Martenson C, Pitkälä KH. A qualitative analysis of student Balint groups in medical education: Contexts and triggers of case presentations and discussion themes. *Patient Education and Counseling* 2008;72(1):5-11.
3. Brock CD, Stock R. A survey of Balint group activities in U.S. family practice residency programmes. *Family Medicine* 1990;22(1):33-37.
4. Botelho RJ, McDaniel SH, Jones JE. Using a family systems approach in a Balint-style group: An innovative course for continuing medical education. *Family Medicine* 1990;22(4):293-295.
5. Kjeldman D, Holmstrom I, Rosenqvist U. Balint training makes GPs thrive better in their job. *Patient Education and Counseling* 2004;55:230-235.

6. Stelcer B. Role of a Balint group in hospice practice. *Progress in Health Sciences* 2011;1(1):171-174.
7. Johnson AH, Brock CD, Hamadeh G, Stock R. The current status of Balint groups in US family practice residencies: a 10-year follow-up study, 1990–2000. *Family Medicine* 2001; 33(9):672-7.
8. Bhavsar J, Chessman A, Brock CD, Johnson A. *Balint group activity in US family medicine residency programs: Comparison to 1990 and 2000.* Presentation at 45th Annual Meeting Society of Teachers of Family Medicine. Seattle, Washington, April 2012.
9. Brock CD, Salinsky J. Empathy, an essential skill for understanding the doctor-patient relationship in clinical practice. *Family Medicine* 1993;25(4):245-249.
11. Brock CD, Chessman AW, Johnson AH, Higgins E, Musham C, Irwin C, Steuer G. Spotting clues in the opening case presentation of a Balint group: Insights from a meta-Balint group. *Journal of the Balint Society* 1994;20:40-43.
12. Elder A, Samuel O. *While I'm here, doctor: A study of the doctor-patient relationship.* London, UK: Tavistock Publications, 1987.
13. Brock CD, Freedy JR, Detar DT, Blue AV, Thiedke CC. *Balint, empathy and professional role integrity: Employing Balint concepts with medical students.* Abstracts of the Proceedings of the 17th International Balint Congress, 2011.
14. Cataldo KP. Association between Balint training and physician empathy and work satisfaction. *Family Medicine* 2005;37(5):328-331.
15. Sekeres MA, Chernoff M, Lynch Jr TJ, Kasendorf EI, Lasser DH, Greenberg DB. The impact of a physician awareness group and the first year of training on hematology-oncology fellows. *Journal of Clinical Oncology* 2003;21(19): 3676-3682.
16. Turner AL, Malm RL. A preliminary investigation of Balint and non-Balint behavioral medicine training. *Family Medicine* 2004;36(2):114-122.
17. Musham C, Brock CD. Family practice residents' perspectives on Balint training: In depth interviews with frequent and infrequent attenders. *Family Medicine* 1994; 26(6):382-386.
18. Graham S, Gask L, Swift G, Evans M. Balint-style case discussion groups in psychiatric training: An evaluation. *Academic Psychiatry* 2009;33:198-203.
19. Bacal HA. Training in psychological medicine: An attempt to assess Tavistock Clinic seminars. *Psychiatry in Medicine* 1971;2(1):13-22.
20. Ghetti C, Chang J, Gosman G. Burnout, psychological skills, and empathy: Balint training in obstetrics and gynecology residents. *Journal of Graduate Medical Education* 2009;1(2):231-235.
21. Margalit AP, Glick SM, Benbassat J, Cohen A, Katz M. Promoting a biopsychosocial orientation in family practice: Effect of two teaching programs on the knowledge and attitudes of practicing primary care physicians. *Medical Teacher* 2005; 27(7):613-618.
22. Kjeldman D, Holmström I, Rosenqvist U. How patient centered am I? A new method to measure physicians' patient-centeredness. *Patient Education and Counseling* 2006;62(1):31-37.
23. Margalit AP, Glick SM, Benbassat J, Cohen A. Effect of a biopsychosocial approach on patient satisfaction and patterns of care. *Journal of General Internal Medicine* 2004;19(5 Part2):486-491.

24. Kjeldman D, Holmström I. Balint groups as a means to increase job satisfaction and prevent burnout among general practitioners. *Annals of Family Medicine* 2008; 6(2):138-145.
25. Balint M. *The doctor, his patient, and the illness,* 1953. Reprinted by Churchill Livingstone, 1988.

Direct reprint requests to:

David Mahoney, MD
Trident Family Health, 2nd Floor
9228 Medical Plaza Drive
North Charleston, SC 29406
e-mail: mahoneyd@musc.edu