Groups Facilitate Self-reflective Practice

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Psychoanalysts rely on a central assumption that there can be no insight into one’s conflicts without anxiety. When individuals in a Balint group discuss their conflicts with patients, their anxiety may lead to defenses. These defenses have to be clarified, confronted, and interpreted if insight is to be obtained into relationships with patients. In a Balint group, the leader’s ability to manage the presenters’ level of anxiety and clarify defenses is essential.

In the paper by Johnson et al on Balint group leadership in this issue of Family Medicine,1 the authors address this and other aspects of leadership. Specifically, they emphasize that Balint group leaders should “create a climate of safety, acceptance, and trust.” This statement invokes positive sounding terms such as “creating a safe space” and being “supportive.” However, such concepts as applied to Balint-type groups are difficult to reconcile with classical psychoanalysis or the writings of Michael Balint.

What Is Support?

Balint questioned the meaning of support when he asked, “Reassurance or support for whom?”2 Is support needed from the leader for the latent or the stated wishes of the physician who is presenting a case? Is support and reassurance needed from the group for something the presenter said or did? Or, are presenters looking for ways to support their relationship with patients? Balint said that “In most cases it is the doctor who needs and gets reassurance and support. Whether patients benefit from it is another matter.”2 Even more generally, Balint argues against the whole notion of reassurance and support because, he points out, we lack knowledge about the dynamics and consequence of providing such reassurance and support.

Finally, there is an incongruity between the stated goals of the supportive approach advocated by Johnson et al and what seems to occur in their residency program. Specifically, if the leaders are effective at creating such a safe and reassuring environment, why is it necessary to make attendance at Balint groups a requirement of the residency—especially after people begin attending the group sessions? Perhaps support and reassurance are not, after all, the key ingredients for a successful Balint group.

Self-deception

In fact, an environment that is too supportive and reassuring may interfere with the goals of Balint-type groups. In family medicine education, one of our goals is to teach young physicians to master self-reflective practice. This goal applies to and is facilitated by group discussions of doctor-patient interactions, such as occurs in residency-based Balint groups. But, initiating residents into self-reflective practice through Balint groups requires groups and leaders who can effectively balance the tension between support on the one hand and probing self-reflection on the other. That is, the leader must assure that the group provides enough “support” to make residents feel willing to participate. But, at the same time, the group must also probe with sufficient depth into residents’ feelings, often using psychoanalytical principles, to assure that residents become aware of their real feelings.

The tendency to deceive one’s self has been recognized by many individuals throughout history. There was Socrates’s injunction to “know your self,” Shakespeare reminding us that “above all, to thine own self be true,” and Swift’s belief that “you don’t know your own mind.” In the realm of psychology, Sigmund Freud noted that we all have difficulty knowing ourselves and remain unaware of “bad ideas, feelings, and impulses” within us.

Freud’s distinct contribution in this area was to spell out the variety of ways in which we defend ourselves from becoming aware of anxiety-provoking feelings, and the concept of defense mechanisms has been assimilated into general psychology and popular culture. But, simply labeling or categorizing these defenses without attention to the intra-psychic dynamics that lead

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to them merely assumes the presence of defensiveness without further inquiry or analysis into its nature and origins. There is, fortunately, a commitment in most Balint groups to learning about one's behavior, defenses, and feelings and their influence on relationships with patients. Probing into these feelings and defenses often requires psychoanalytic techniques, and it is not clear that the group leadership skills described by Johnson et al include the ability to apply these techniques.

Composition, Attendance, and Leadership of Groups

While Johnson et al comment on the need for an effective leader, balancing the tension between a psychoanalytical approach and the supportive orientation also depends on the composition of the group. There is currently considerable diversity nationally with respect to the composition of residency-based Balint groups, to policies regarding attendance by group members, and to the professional backgrounds of the leaders of such groups. Techniques and approaches that work in one residency program may or may not work in another.

Composition

Groups may be composed according to two very different principles—namely, groups based on "horizontal" or "vertical" integration. In horizontal integration, all members of resident groups, except the leader(s), belong to the same year in the residency. Faculty, if they have a group, belong to their own group. In vertical integration, residents from multiple years and faculty can all belong to the same group. Another variation is that in some residency programs, the department head or residency director is a member of a group (but not usually a group leader), while in other programs, the head/director is not involved. In matters large and small, the psychological conditions for revealing one's vulnerabilities are not optimal when an authority figure such as the department head or residency director is present. It would be interesting to know the frequency with which department heads and program directors are involved in residency-based Balint groups either as participants or leaders and the perceived effect of their involvement.

Attendance

Policies regarding attendance also vary considerably among programs. Attendance is not usually required for faculty physicians, and there is variability in the degree to which residents are required to participate in Balint groups. Issues for a traditional Balint group leader that are not addressed in Johnson et al's article include whether and how the leader, concerned with group norms, should deal with a resident who does not attend every meeting, or who is late for meetings, or who leaves before the end of meetings. Such departures from group norms are "interpreted" in a traditional Balint group using psychological concepts. In contrast, Balint-type groups as they exist in many current residency programs may overlook or even overtly permit such behaviors.

Leaders

The professional backgrounds and preparation for leading a group based on some version of psychoanalysis is not articulated in the article by Johnson et al. How much knowledge of psychoanalysis is it desirable for the leader to have? Should leaders have experienced some form of psychoanalytically oriented psychotherapy as part of their training? How knowledgeable and immersed in the culture of family medicine should the leader be? Is it better to have two leaders rather than one, representing both the medical and the psychological perspectives? The article does not specifically address these issues, though they are key to our understanding of effective Balint group leadership. More study is needed to answer these questions.

The Issue of Certification

The article by Johnson et al assumes that certification of leaders by the American Balint Society is desirable. However, the article presents no data to support the benefit of certification, nor does the described certification process seem to have any quality control. For example, are there any competency examinations related to certification? Is certification as a Balint leader to be for a limited or an unlimited time period? Does a certified leader have to earn educational credits comparable to continuing medical education credits to maintain status as a certified leader? And, is there evidence that noncertified leaders are less effective than certified ones?

Attendance at American Balint Society (ABS) meetings, as discussed in the article, is an undoubtedly effective way to learn and keep current with Balint techniques. Indeed, members of my department's faculty who have attended ABS meetings will attest to this. But, attendance and participation in meetings do not, all by themselves, assure competence. And, surely, individuals can be effective and competent group leaders even if they do not belong to or participate in ABS meetings and even if they are not certified by ABS. There must be some other, more "evidence-based" way to measure and assure competence.

Science and Balint Groups

Finally, one of the most questioned aspects of Balint-type groups, also not discussed in the article, is their scientific status. From the perspective of mainstream science, Balint groups have never been assessed for the validity and reliability of the observations provided by group participants, nor of the descriptions of interactions with
patients. Rather, there is a reliance on the self-reports of the presenter and the interpretations by group members and the leader. Time and money, the usual culprits, have largely eliminated the review of videotapes of resident-patient interactions—a technique that was widely used in family medicine residencies during the 1970s and early 1980s to verify the quality and nature of residents’ encounters with patients. Now, without the ability to observe and verify the nature and content of resident-patient interactions, we must rely only on self-reports, which are vulnerable to examination through the lens of defense mechanisms and self-deception mentioned earlier.

Where Is the Patient?

Beyond the status of Balint groups in the eyes of the mainstream scientific community, and beyond the issues of group composition and leaders, is a deeper question. That question is “What about the patient?” Why has medicine and psychology omitted the “person” we all say we want to understand and help? We sit in Balint groups and attempt to improve physician-patient relationships by working only through the point of view of physicians. Patients are not present and have no opportunity to evaluate what is being said about them. I am still enamored by the ideals of family medicine conveyed by Gayle Stephens’ statements, such as “A diagnosis is not a name. You have to know a patient’s name,” or the research by Ian McWhinney on patient-centered relationships.

Thus, while Balint groups appear to offer benefits to family medicine trainees, it is likely that until we involve patients in the training process, we have not yet found the optimal way to enhance our residents’ interactions with patients. My values lead me to conclude that we might do better if we could do this.

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REFERENCES