Commentary

Reframing Balint: Thoughts on Family Medicine Departmental Balint Groups

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This paper explores recurrent processes and themes in the 1,300 family medicine faculty, resident, intern, and community Balint groups the author has facilitated/led. The frequent group “deviation” from the central Balint task of understanding difficult physician-patient relationships is reframed as less “resistance” or “obstacle” to work, as it is an expression of unmet developmental needs and organizational realities. When group members are carefully attended to (by facilitator and one another), the group often becomes emotionally capable of addressing a “case” in the conventional Balint understanding of the work the group has assembled to do. The group dynamics of such “hybrid” Balint groups thus become comprehensible as other than error.

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In this paper, I will attempt to make sense of what is not supposed to happen in physician groups named for Michael Balint, describing some of the observed “deviations” and presumed errors in Balint groups. In particular, I will discuss what happens when the group itself, and not a patient, is allowed to be the “case.” In my family medicine department, I coordinate and lead or facilitate all Balint groups for interns, residents, and faculty at three residency training sites, a role I have occupied since the middle 1980s. I have led some 1,300 groups during that time.

Balint Groups: Ideal and Real

What kind of group is a Balint group? What is (are) the purpose(s) of the group, and whose group is a Balint group? The original Balint group in England consisted of a psychiatrist and about five to seven practicing general practitioners. Group members were physicians whose professional identities and roles had already congealed. In contrast to the issues and identities of those British general practitioners, there are different issues, identities, and roles among the interns, residents, and faculty physicians involved with Balint groups in US family practice residencies.

Balint groups were originally designed to be specific “work groups” in Bion’s sense of the term. The focus of the group was the task of presenting a case, helping members to more deeply understand the physician-patient relationship involved, and returning to clinical practice with greater wisdom. The group was not designed to be supportive or to analyze unconscious aspects or emotion-based basic assumptions of the group process itself.

Merenstein and Chillag document from ethnographic observation, interviews, and focus groups how the actual practice of Balint group leadership in family practice residencies—and hence the group process itself—widely deviates from Michael Balint’s original model and from later International Balint Society doctrine. The groups as constituted in family practice departments and programs differ from traditional groups in that they provide support, offer reassurance, provide teaching and guidance, provide answers, are hierarchical, and are willing to give the “right answer.”

The remainder of this paper elucidates the nature of this discrepancy in groups in which I have been member and leader. Instead of enforcing “what should happen,” I pay attention to what does happen and what can happen when one takes cues from the group as well as from doctrine. Indeed, I question whether Balint orthodoxy is always appropriate, or even possible, for intern, resident, and faculty groups whose members’ developmental needs and group boundaries differ from those of the seasoned practitioners in classic Balint groups.

Key Differences

In the US family practice residency groups, group facilitators readily respond as issues surface, strive to take priority, and ask to be
acknowledged and addressed. In these residency-based groups, within the boundaries of confidentiality and respectful listening (which are core Balint values), we learn together what needs to be addressed.

Often, group goals and processes must precede the capacity of interns, residents, and faculty to process the human dimensions of difficult or vexing physician-patient interactions. Intense, case-focused discussions may occur in the second part of the hour’s meeting, after issues of psychic survival, fragmentation, and self-worth have first cleared the air. Internal and interpersonal issues among interns, residents, and faculty must first be recognized and addressed if participants are to have an emotional reservoir of empathy toward patients.

Some Balint Themes and Processes

Several core realities converge in the Balint groups I have led. First, these groups are one of the few places and times in which interns, residents, and faculty (in separate groups or in combinations) see each other and have the opportunity to meet. Second, these groups have historically been one of the few emotionally safe places in the department and in the health sciences training environment. Third, these groups are one of the few places in the larger organization where participants are able to affirm their identities as family physicians and feel good and competent about it. Over time, Balint groups have increasingly become a kind of rehearsal place or testing ground for presenting and addressing group issues and ideas in wider departmental settings.

During a typical group, either I or the co-leader will (1) inquire how the month’s rotations are going, (2) listen to the group conversation for a theme or a case that might become the group focus, or (3) directly ask if anyone has a case. Because I have already provided group members with a history of the original groups, and passed out a packet of reading materials about Michael Balint and his early groups, group members know what the call for “a case” signifies. Usually the group will land on a theme, or I will discern one out of the conversation.

Often, a Balint group will consist of two groups, the larger group that begins the hour together and a smaller group that stays after a number of members leave for clinic or for other reasons. The former (larger) group will be cathartic and engage on a more superficial level. The latter (smaller) group often takes on the intense, introspective quality of classic Balint groups. Over the hour, the group frequently progresses from anger, sarcasm, splitting, projection, and blame to reflection, ownership of feelings, and compassion.

Conclusions: Learning From Experience in Balint Groups

What may appear to be “obstacles” or “deviations” of residency Balint groups from classic Balint groups are actually necessary developmental steps that take place through “learning from experience.”11 By widening and re-framing—putting a new “frame” around the same content—the concept of “case,” one can foster an atmosphere where all participants’ psychic and real-world realities are taken seriously. Balint participants are often able and willing to discuss a Balint-type clinical case once their own experiences are given voice, acknowledged, and validated. As Shapiro writes: “People cannot take care of the ‘work’ until they take care of themselves” (personal communication with Johanna Shapiro, PhD, May 16, 2002)—until they feel taken care of in the group context. The Balint groups I have discussed in this paper are places in which both can occur.

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References