Residents Physicians Who Continue Balint Training: A Longitudinal Study 1982–1999

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Background and Objectives Balint seminars began in London in 1950 on a voluntary basis for general practitioners wishing to explore psychological problems in their practice. By 1964, there was a 36% early dropout rate among the 223 physicians who participated. This study sought to determine if those who leave Balint training during their residency, versus those who continue, have different psychological characteristics. Methods: A retrospective analysis of 206 Medical University of South Carolina family practice residents from 1982 to 1999 was completed. All residents participated in 6 months of required Balint training and then could leave the Balint group or continue for the remaining 2 years. We examined gender and personality attributes, comparing residents who completed 2 years of weekly Balint training and residents who left after 6 months. Personality attributes were measured with the Myers-Briggs Inventory, the Work Environmental Preference Schedule, the Internal-External Locus of Control, the Fundamental Interpersonal Relationship Orientation Behavior test, and the Personal Orientation Inventory.

Results: A total of 132 residents completed 2 years of weekly Balint training, and 74 discontinued training after 6 months. Two-year attendees were significantly more intuitive on the Myers-Briggs Personality Inventory (MBTI). There were no significant differences on other MBTI items, nor were there significant differences in gender or in scores on the other psychological tests. Conclusions: Based on the rate of discontinuation of Balint training in our sample, Balint work does not appear to be suited to all physicians. With the exception of one MBTI characteristic, no significant differences could be demonstrated between those who did and did not continue participating. Further study is necessary to define other attributes characterizing Balint group attendees and nonattendees.

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In the fall of 1950, Michael Balint began his first seminar for general practitioners in London at the Tavistock Clinic.1,2 The purpose of these seminars was to explore difficult doctor-patient relationships, with the intent of helping physicians find new and more therapeutic ways of relating to patients. By January 1964, 223 family physicians had taken part in this series of “case discussion seminars” that eventually evolved into the Balint training process for clinicians. In the early years of this process (1950–1954), all doctors who applied to the course were accepted. Between 1954 to 1958, however, a “reshuffling” of participants resulted as physicians left groups, and the number of participants in some of the groups declined to fewer than four. In these instances, the group with less than four participants was discontinued, and those remaining were reassigned to other groups. Balint’s assessment of the “early leavers” was that they were either “seriously neurotic,” “insecure with obsessional defenses,” “overly anxious,” or limited by time or intelligence. Other early leavers, he said, were simply “non-disclosing” and “hoddescript.” A majority of those who remained more than 2 years gained “versatility” and “tolerance” for handling patients and skill in effectively listening to them as well as their group peers.

Starting in 1959, a new process, termed the “mutual selection interview” was introduced as a way of regulating or selecting participants when it became clearer that Balint training was more suitable for some individuals than others. Similar selection schemes were undertaken at a number of other institutions in England, Germany, and the United States as Balint training became more widespread. However, there were never any

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formal processes identified to help in the selection of individuals who might be most suitable for Balint training. For example, no objective psychological testing of applicants was undertaken to assess whether certain personality preferences were associated with continuation in Balint training. As a result, while Balint training might not be for everyone, it is still unclear who it suits and who it does not.

Balint training has a long history at the Medical University of South Carolina (MUSC). Balint groups were first introduced into the MUSC family medicine curriculum in 1981 on a voluntary basis. The next year, it was decided that weekly, 1-hour Balint groups would be mandatory for residents during the first 6 months in their second year of training, and participation thereafter would be voluntary. This practice continued for the next 18 years, with the same faculty member leading the Balint group. Over the same time period, all residents entering the MUSC Family Medicine Residency were given an extensive battery of psychological tests, almost all of which were to measure normal personality attributes. This gave us the opportunity to explore whether continuation in Balint groups, at least while in residency training, can be related to certain personality characteristics.

This study’s aim was to explore personality attributes that are more common in residents who continued in the Balint group past the required 6 months than among those who did not. The hypotheses that were tested were that Balint participants are more likely to be more open minded, process oriented, and have a higher internal locus of control and capacity for intimate contact. In addition, we hypothesized that individuals who exhibited preferences for extraversion, intuition, and perception on the Myers-Briggs Type Indicator (MBTI) would be more likely to remain in Balint training for their entire course of their residency training.

Methods

This study was approved by the Review Board of the Medical University of South Carolina.

Subjects

We performed a retrospective analysis of 206 residents (137 males [67%] and 69 females [33%]) who attended the MUSC Family Medicine Residency Program between 1982 and 1999 and who were exposed to Balint training during residency. A total of 132 residents (65%) continued through 2 years of weekly 1-hour Balint groups after the initial 6-month period of requested participation (attendees), while the remaining 74 (35%) discontinued weekly Balint group participation after the required 6 months (nonattendees). Four Balint attendees and three nonattendees were excluded from analysis because they entered residency after psychological testing was completed for their cohort of residents (ie, these residents did not undergo psychological testing). Eighteen percent of the remaining 206 residents were MUSC graduates, 74% were graduates of 68 other medical schools from 30 states plus the District of Columbia, and 8% were graduates of 10 foreign medical schools.

Psychological Tests

Numeric scores from six psychological tests were used to assess the various constructs that we wished to test. These tests are shown in Table 1.

We looked specifically at participation in Balint and three subscales on the MBTI: “perceiving,” which indicates a preference for living in a flexible, spontaneous manner, seeking to explore life rather than label, schedule, and formalize it; “Intuition,” which indicates taking in information by looking for the big picture and imaging the connection between the facts; and “extra-version,” which refers to people who focus attention on the outer world of events and people and derive energy from doing so.

For the Rokeach score, higher scores indicate a more closed-minded individual (Table 1). The Work Environmental Preference Schedule (WEPS) measures bureaucratic orientedness, and scores increase as a person becomes more self subordinating, more impersonal, more compartmentalized, more role or rule conforming, and more traditional. Rotter’s Internal Versus External Locus of Control scale yields higher scores with increasing belief in an external locus of control (ie, a belief that responses to one’s behavior are not entirely contingent on it but are influenced by chance, luck, or some other external forces). Higher scores on the two variables derived from Schutz’s Fundamental Interpersonal Relationship Orientation Behavior (FIRO-B) scale indicate an increase in taking initiative in relationships and a greater desire for increased interpersonal interaction. Shostrom’s scale measures the capacity for intimate contact and increases numerically with that capability.

Each of the six tests was administered during the first month of residency under classroom-monitored conditions to all incoming first-year residents (excluding the seven residents previously mentioned). Residents completed the tests as a group, and their responses were analyzed by one of the authors and remained confidential (except for feedback provided only to the individual residents themselves).

Data Analysis

The results of the psychological tests were compared for attendees and nonattendees using either chi square (for categorical variables) or t tests (for normally distributed continuous variables). Differences were considered significant if the P value was <.05.
Table 1

Psychological Tests

<table>
<thead>
<tr>
<th>Construct</th>
<th>Test Used</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Open mindedness</td>
<td>Rockeach Dogmatism Scale, Form E(^6)</td>
<td>Higher scores = more closed minded</td>
</tr>
<tr>
<td>Preference for perception (P) versus judgment (J)</td>
<td>Myers-Briggs Type Indicator (MBTI)(^7)</td>
<td>Higher P score = more spontaneous</td>
</tr>
<tr>
<td>Preference for intuition (N) versus sensing (S)</td>
<td>Myers-Briggs Type Indicator (MBTI)(^7)</td>
<td>Higher N score = more imaginative</td>
</tr>
<tr>
<td>Preference for extroversion (E) versus introversion (I)</td>
<td>Myers-Briggs Type Indicator (MBTI)(^7)</td>
<td>Higher E score = more extraverted</td>
</tr>
<tr>
<td>Orientation preference (process versus bureaucratic protocol)</td>
<td>Work Environment Preference Schedule (WEPS)(^8)</td>
<td>Higher score = more bureaucratically oriented</td>
</tr>
<tr>
<td>Locus of control (internal versus external)</td>
<td>Internal-External Locus of Control (IE)(^9)</td>
<td>Higher score = higher external locus of control</td>
</tr>
<tr>
<td>Preference for taking the initiative in relationship, d</td>
<td>Fundamental Interpersonal Relationship Orientation Behavior (FIRO-B)(^10)</td>
<td>Higher d score = taking more initiative in relationships</td>
</tr>
<tr>
<td>Preference for a high degree of interaction with others, Σ</td>
<td>Fundamental Interpersonal Relationship Orientation Behavior Scales (FIRO-B)(^10)</td>
<td>Higher Σ score = higher degree of interaction with others</td>
</tr>
<tr>
<td>Capacity for intimate contact, c</td>
<td>Personal Orientation Inventory (POI)(^11)</td>
<td>Higher c score = higher capacity for intimate contact</td>
</tr>
</tbody>
</table>

Results

Over the 18 years of observation, 65% of our family practice residents participated in Balint training longer than the required 6 months (ie, attendees). Annually, participation ranged from a low of 36% to a high of 92% (Figure 1). In general, more males than females participated in the residency Balint program after the required 6 months, but this reflected the overall gender composition of the residents. The relationship between gender and several psychological measures and participation in Balint training for the entire residency is shown in Table 2. There was no sig-
nificant relationship between gender and participation after the required 6 months.

The intuition variable on the MBTI showed a statistically significant difference between Balint attendees and nonattendees (Table 2). The other two MBTI variables did not demonstrate a statistically significant association with attendance at Balint groups. Table 3 shows that none of the 16 MBTI types was statistically significantly overrepresented or underrepresented in the sample of 132 Balint group attendees.

As noted in Table 2, no significant difference was noted between attendees and nonattendees in scores on the Rokeach test, the Work Environmental Preference Schedule (WEPS), Rotter’s scale, the FIRO-B, and Shoström’s scale.

Discussion

We had hypothesized that physicians with certain MBTI preferences would be more likely to participate in Balint groups. We only found, however, that Balint attendees were more likely to be classified as “intuitive” on the MBTI. None of the other MBTI psychological types was more common in the Balint group attendees (Table 3). Thus, Balint group attendees are not just one type of person—they are a heterogeneous group sharing some similar attributes. Further, our analysis suggests that neither gender nor characteristics on any of the other psychological tests were more common in attendees versus nonattendees.

One would expect significant homogeneity among residents following 8 years of comparable, formal education and a mutual selection process leading to matriculation in the Charleston residency. Therefore, it is not unexpected to find few significant differences among several psychological measures taken in this population, though a larger or more heterogeneous population might have had more differences in the test variables.

We hypothesized that Balint attendees would be more intuitive than the nonattendees, and we found a statistically significant difference in this characteristic between attendees and nonattendees (P=.05). This finding, however, may be an example of the Type I error (a difference detected by chance, rather than one representing a true difference). Type I error at a P value of .05 occurs five times in 100 by chance, and possessing the MBTI intuitive characteristic made a selection criterion for inclusion or exclusion of participation in a Balint group. Rather, it may just suggest a general way of perceiving that may be more common among attendees and also suggest, in part, what creates the particular, speculative, and reflective ambiance of a Balint group.

Table 2

Comparative Statistical Analysis of Medical University of South Carolina Family Practice Resident Balint Group Attendees and Nonattendees

<table>
<thead>
<tr>
<th>Test Variable</th>
<th>ATTENDEES (n=132)</th>
<th></th>
<th>NONATTENDEES (n=74)</th>
<th></th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>X</td>
<td>SD</td>
<td>%</td>
<td>X</td>
<td>SD</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>64</td>
<td>36</td>
<td>72</td>
<td>72</td>
<td>28</td>
</tr>
<tr>
<td>Female</td>
<td>41</td>
<td>76</td>
<td>41</td>
<td>51</td>
<td>.947</td>
</tr>
<tr>
<td>MBTI-P</td>
<td>131.22</td>
<td>23.62</td>
<td>130.16</td>
<td>22.72</td>
<td>.757</td>
</tr>
<tr>
<td>MBTI-N</td>
<td>24.42</td>
<td>6.76</td>
<td>6.68</td>
<td>.094</td>
<td></td>
</tr>
<tr>
<td>MBTI-E</td>
<td>9.68</td>
<td>5.11</td>
<td>8.58</td>
<td>.124</td>
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</tr>
<tr>
<td>Initiative in relationships, d</td>
<td>-2.48</td>
<td>3.17</td>
<td>-2.93</td>
<td>.939</td>
<td></td>
</tr>
<tr>
<td>Interpersonal interaction, Σ</td>
<td>26.98</td>
<td>8.6</td>
<td>26.89</td>
<td>.946</td>
<td></td>
</tr>
<tr>
<td>Capacity for intimate contact, c</td>
<td>18.14</td>
<td>3.48</td>
<td>18.39</td>
<td>.608</td>
<td></td>
</tr>
</tbody>
</table>

SD—standard deviation

MBTI-P—Myers Briggs Type Indicator (perception)
MBTI-N—Myers Briggs Type Indicator (intuition)
MBTI-E—Myers Briggs Type Indicator (extraversion)
We also hypothesized that Balint attendees would be less bureaucratically oriented than nonattendees and that they would be more internal than external in their locus of control. Neither of these hypotheses was supported by the results of our study. And, as noted, we found no differences between attendees and nonattendees in any of the other psychological test results.

Our findings regarding participation rates are similar to those obtained by Balint in his 14-year study of participants in his Tavistock clinic. His data showed that 36% of participants drop out of Balint training in their initial year. Our results showed that, when given the choice, 35% of residents also drop out of training after an initial 6-month period. Balint also observed that those who discontinued group membership usually did so within the first year of participation. These findings should be considered carefully by educators who want to incorporate Balint training into residency programs.

Limitations

The conclusions of this study should be interpreted in light of some limitations. Factors creating group cohesion or fragmentation within the residency were not measured and certainly may contribute to residents staying in the group or leaving it. Likewise, residents’ sense of loyalty or attachment to the faculty member leading the group may influence group participation.

A second limitation is the lack of power that could be achieved with the sample size. Two of the psychological variables that we considered (bureaucratic orientation and locus of control) showed trends that suggested differences in the way that attendees view the world, but neither of these differences achieved statistical significance. A post-hoc analysis concluded that a sample size of approximately 400 individuals would be necessary to achieve a power of 80% at an alpha level of .05 to demonstrate significant differences for either of these variables, and we only had data on 206 residents.

Conclusions

Our results show that psychological measures alone will not answer the question of who will choose to participate in Balint training. To the extent that Balint training provides benefits for residents (something not measured in this study), we hope our results illustrate some of the interactions, or lack thereof, of physicians who opt to participate in Balint training.

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References


