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Trainees' experiences of a Balint group

Psychotherapy training is mandatory before trainees can gain membership of the Royal College of Psychiatrists. One type of introduction to psychotherapy is via a case discussion group, such as the one pioneered by Michael Balint. Much has been published regarding psychotherapy training, but little describing the Balint method from a trainee's perspective. Our paper outlines trainees' experiences of participating in this type of group. The group encouraged trainees to think about the doctor–patient relationship in their everyday clinical practice. All of those who finished the group described a positive experience, giving a good grounding for further psychotherapy training.

Background

Since the Royal College guidelines for psychotherapy training were published (Royal College of Psychiatrists, 1993), it has been mandatory to train in psychotherapy before gaining membership of the College. However, the type of training varies across schemes, depending on the resources available (McCrindle *et al*, 2001). In Sheffield, trainees progress from a case-discussion (Balint) group to a theory-based course over a time-frame of 18 months to 2 years.

A Balint group is a form of case-discussion group, originally developed by Michael Balint in the 1950s for general practitioners. These groups should be small (6–12 people), closed, continue for at least 6 months and have a leader who has training in psychotherapy and Balint groups (Hopkins, 1994). Most meet weekly and a member will present a patient who they are having difficulties with. The purpose is to explore the doctor–patient relationship, through which process an understanding of psychological issues develops.

Our group was unusual in that it was comprised entirely of psychiatric trainees and not general practitioners. It continued for a year and was co-led by a consultant psychiatrist (specialising in analytic psychotherapy) and a specialist registrar in general psychiatry. Previous work has described the process and experience of training in individual psychodynamic psychotherapy (Paul & Bluck, 1997; Wilson, 2001), but we are not aware of any literature describing psychiatric trainees' experiences of Balint groups. When our group ended, trainees met to discuss their experiences.

Reasons for joining the group and expectations

Most members (if honest) replied that they attended the group because it was mandatory, although this was not the sole reason. A significant minority also expressed genuine interest in the subconscious workings of the patients' minds. Some, altruistically, wanted another way of helping 'without tablets'. Most wanted to be able to incorporate psychotherapeutic options into a patient's overall management. All of us had been 'stuck' with patients and hoped to gain some insights via the group.

The majority had no previous experience of psychotherapy, and therefore came with a variety of preconceptions (mostly misconceptions). Chief among these was that it would be very 'touchy-feely', 'sandal-wearing' and of little real use in clinical practice. Those of us who were working towards our Part I MRCPsych thought that there would be a rather dry discussion about defence mechanisms and little else. The one member who had attended a Balint group elsewhere described an interminable hour of long, uncomfortable silences.

First impressions

The initial feeling was one of overwhelming fear when we were asked if any of us had a patient to present. We started off by presenting in the medical model, omitting any feelings or emotions we might have about the patient. We all attempted to avoid any discomfort by talking about medication, insight and other comfortable 'psychiatric' areas we knew about.

In the end, we were always urged to return to the doctor–patient relationship. None of us wanted to go back to it as we feared saying something 'stupid' or 'wrong' in front of our colleagues, and we felt unable to use the correct terminology to describe what we were thinking. We became conscious of our lack of knowledge, as well as being afraid to express our true feelings

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towards (some) patients. A great many euphemisms were used in the first few weeks and months – 'interesting', 'mildly annoying', 'misunderstood', 'difficult' – everyone was scrupulously polite. Even when pushed to admit how we really felt, we still adamantly maintained that we would not allow ourselves (or were not allowed) to develop such strong feelings regarding our patients. However, once one of us tentatively admitted that, yes, we did find a patient immensely irritating, then the flood gates opened. It was at this point that we were really talking about the doctor–patient relationship.

And onwards . . .

It took us some time to develop the necessary mindset or way of thinking about a patient. Even after several months, we could be caught talking about specifics rather than speculating on unconscious feelings and how these might be reflected in the doctor–patient relationship. As it was so easy to get waylaid, the group leaders would keep us on track by making enlightening comments to guide us in the right direction. If we still remained blind, they would take a more direct approach to guide us.

The strict boundaries also took some getting used to. Try as they might, a few members could never arrive on time. Turning up late also had the advantage that someone would have already volunteered to present. Although we had been told of the consequences if none of us had a patient, we did not really believe it. So, when this actually arose and the leaders insisted we sat there for the next hour in silence, we were all stunned. After several minutes, one of us could bear it no longer and asked incredulously 'we're not really going to sit here for an hour are we?' The rest of us silently applauded her. Unfortunately the answer was 'yes', and faced with this, with some difficulty, one of us eventually remembered a suitable patient. After this, we had overwhelming anxiety about having a patient ready. There was always an air of smugness around those who had presented recently, and conversely, increasing desperation in those whose unofficial 'turn' was coming up.

Then, as we progressed, we began to truly value the insights we gained from bringing cases to the group. Sometimes, more than one of us would have a patient we wanted to present and we would fight over the privilege rather than shy from it. In our clinical practice, we would cast a new eye over patients previously forgotten (maybe 'overlooked' deliberately) and re-examine why they caused us such problems. Gradually, we came to appreciate the hour and fifteen minutes on a Thursday morning as a time when we did not have to think about drug side-effects or multi-axial diagnoses and instead could reflect on our interactions with patients.

In hindsight (eating our words)

Despite our misgivings and negative feelings at the start, when we met up later to write this paper we all admitted (slightly sheepishly) to missing the group and wished it could have continued longer. We found, with surprise, that we had learnt some theory – almost through a process of 'psychological osmosis', as we had received little formal teaching. Individual patients' problems would illustrate difficult concepts, bringing them to life so that we understood much more clearly. Eventually, we were able to adopt some of the language and (although we were not taught specifically how to do it) even the least confident of us was able to prepare a psychological formulation for the Part I MRCPsych clinical exam.

Of course, there were some drawbacks. There were several trainees who stopped attending over the course of the year. Some left the rotation, but others may not have found the Balint group to their taste. Any form of discussion in a group setting will not suit everyone as a few may be too shy to speak. However, the group leaders encouraged all contributions and none received negative responses (at least initially). There was also quite a diverse cultural mix within the group and it may well be that some people found it unacceptable to discuss patients in this way because of their own backgrounds. Certainly in some cultures, the doctor–patient relationship is much more formal and expressing emotion is frowned upon.

Most importantly, however, our attitudes to 'difficult' patients had changed – not that we suddenly had a magic solution and could breeze through the ward with a satisfied smile on our collective lips. Before, we would be drawn into conflicts and experience emotions that we found shameful or embarrassing. Now we still felt the same way, but could use this to contribute to the therapeutic process. All trainees who finished the group enjoyed it and felt that the way they thought about patients had changed. The group was not hard to follow or weighed down with complicated concepts, but gave us a taste of psychotherapy training and an insight into the doctor–patient relationship. It left us not only with an interest in psychotherapy, but a drive to know more.

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