

The Use of Individualized Balint Training in One-On-One Teaching

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The traditional venue for Balint training has been to study the relationship between one doctor and one patient at one time in a group setting¹⁻². The group usually consists of physicians and a leader, who is either a physician or non-physician. Historically, Balint group was initiated with practicing physicians. It is now common to use Balint group in medical training programs³. This paper stems from a serendipitous finding that family practice residents will "Balint" patients with individual supervisors after exposure to Balint group. The method of presentation for *individualized* Balint follows the same structure for presentation in Balint group. The setting for *individualized* Balint has ranged from the preceptor room or the hallway to a more structured one-on-one supervision time designed to enhance physicians' skills in counseling patients. The purpose of this paper is to highlight the usefulness of the Balint process as a teaching tool with one doctor at a time.

It is obvious that a given physician's enthusiasm for Balint training varies greatly and is not only due to how defended the physician is about their feelings towards patients. Other factors, including personality style, such as assessed by the Myers-Briggs, influence interest in and reported satisfaction with Balint group as a method of learning about the doctor-patient relationship.⁴

Another factor is the physician's degree of comfort participating in a group.⁴ following case illustrates a pragmatic advantage of providing a format for *individualized* Balint as a teaching tool.

Dr. B, a third-year family practice resident, was well respected and liked by her colleagues and faculty. Her psychosocial skills with patients were above average. Her attendance at Balint group was sporadic, with little to no participation despite encouragement by the Balint leader. Dr. B was also adamant about not wanting to be videotaped during her patient care, but acquiesced to the training program requirement. She faced presenting her compulsory grand rounds with the utmost trepidation. Clearly what emerged was a picture of a physician who was shy and reluctant to present or participate in front of a group. This same physician was quite responsive to one-on-one supervision around issues pertaining to the doctor-patient relationship and discussed a number of her patients from the viewpoint of how she responded to them.

One case in particular provided evidence of her insight into the Balint process. Dr. B was frustrated and mad at a 45-year-old woman diagnosed with ovarian cancer who was refusing to follow up with her oncologist. Upon further reflection, Dr. B admitted that she had also been negligent in not touching base with the oncologist. She began to explore both the patient's and her own denial about the disease. This led Dr. B, who was pregnant with her first child, to reveal a concern about the possibility of her being HIV+ from an inadvertent needle stick. "What good will it do if I find out?" With these words she recognized the parallel process of denial in her patient. "I guess," she said, "my patient also doesn't want to find out." Dr. B concluded this encounter stating, "This really does help, it's like my own psychotherapy, the same issues I have are the issues my patients have."

Here was a physician who might well have bypassed gaining Balint skills if the only setting to acquire such skills was a group. In the security of a one-on-one relationship Dr. B was able to risk exploring her feelings. For the Balint teacher it was very gratifying to hear a physician so clearly express an understanding of and appreciation for the Balint process.

The second case illustrates a different aspect of *individualized* Balint. The physician here, Dr. P, also a third-year resident, was a regular and active attendee of Balint group. He understood the Balint process well and if he would present a patient during individual supervision, he would preface it by saying, "I'd like to Balint this patient."

Dr. P's patient was a ninety-year-old shut-in who had been receiving her medical care with the family practice residency for close to fifteen years. A unique aspect of her care was that all her medical visits were done by house call. Dr. P had inherited her care in the same manner as the residents who preceded him. He was asked if he would be willing to care for a rather sweet, old lady who needed to be seen at home. During his care of her, Dr. P had increasingly become more drained by the arrangement of home visits, as his patient was hospitalized twice and required more

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monitoring, both at home and in the hospital.

At the time of presentation, Dr. P was beginning to talk with his patient about transferring her care upon his graduation. At first, he discussed how difficult her care had become, how he certainly wouldn't have time to care for her when he entered private practice and how the patient expected him to turn her care over to some "young physician." What emerged next was how fond he had become of his patient. She had knitted booties for the birth of his child and would always insist on his leaving her house with some fresh baked rolls or cake.

During the discussion, Dr. P explored his feelings about his patient. The issues that kept surfacing were feelings of warmth and intimacy opposed by defining the limits of relationship and avoiding closeness. This was true not only for the doctor but for the patient as well.

Two weeks following this discussion, Dr. P presented the same patient in Balint group. His main concern continued to be focused on whether to continue as her doctor after graduation. As the discussion unfolded, Dr. P shared with the group other emotional reactions that had not surfaced in his individual Balint session. In the group he divulged how painful he thought it might be to watch his patient "go downhill," then brought the group to total silence when he said, "I'm scared of growing old."

In this case, individual and group Balint process brought out different aspects of the physician's feelings toward his patient, all of which had a bearing on his concern about continuing to care for her. Of note is the level of intimate revelation that occurred in the group more than in the individual session.

These two cases illustrate some benefits of *individualized* Balint in teaching physicians. There is no doubt that Balint group as it was designed has many advantages in comparison to *individualized* Balint, the least of which is the input of a larger audience of participants. The purpose of this paper is to describe a method we have called, "*Individualized*Balint," and highlight its place, alongside Balint group, in promoting physician self-awareness. Individualized Balint attains the care aims of group Balint, as it too functions in (a) encouraging doctors to value interpersonal skills and appreciate their limits, (b) improving doctors' understanding of their patients' communication, and © allowing doctors to be aware of blind spots in their interactions with patients.⁵ For some, *individualized* Balint may prove to be a more accessible learning structure than group Balint. For others, it may provide synergism with what is learned in the group and can act as a forum for pre- or post-discussion of Balint issues arising in group. Most of all, it allows physicians to be thinking about the Balint process in an even more ongoing way, anticipating the possibility that every teaching encounter, be it in the preceptor room, in individualized supervision, or a formalized group is an opportunity to learn more about the doctor-patient relationship.

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