

Article

Balint groups as 'shared care' in the area of mental health in primary medicine

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ABSTRACT

This paper describes how Balint groups can be effective for primary care doctors and how leaders of these groups can act as role models in the interdisciplinary, experiential learning experience. The paper describes the way Balint activity helps the facilitation of a dialogue between mental health professionals and primary care physicians. While these groups have been found to improve the sensitivity of doctors in their interaction with patients, Balint groups, with the joint

leadership of professionals from different disciplines, can be seen as an effective method to improve primary care and mental health cooperation. These issues are discussed and appropriate examples outlined offering an uncommon perspective on an interesting topic to promote an integrated, shared model of care.

Keywords: Balint groups, mental health, shared care

Introduction

Some 35% of patients treated by primary care physicians have significant mental health problems.¹⁻³ Many of these problems are not detected.⁴ A greater number are appropriately detected, but not properly treated, and only about 10% are referred to mental health services.⁵ Therefore the cooperation between mental health professionals and primary care physicians should be improved. This can be done in various ways, e.g. provision of more training for primary physicians in mental health, additional reaching out of mental health services into the community, more openness of these services and regular mental health consultations and supervision

in primary care clinics. The latter has been described as the act of 'looking after people rather than looking over their shoulders'.⁶ Consultations may work according to the model of 'shifted outpatients' or of 'consultation liaison' (or a mix of these). Mental health professionals may also be permanent members of the primary medicine team. A further model is to have group meetings of the primary care team with the consulting psychiatrist and/or psychologist. Sharing patient narratives between professionals through correspondence can be seen to be another way to improve cooperation.⁷

In Israel, there have been various other ways of fostering cooperation between mental health and primary care professionals. For example, between the years 1993 and 1995 a two-year six-hour weekly course (the Shiluv course) was run for 20 primary care and mental health professionals, 10 from primary care and 10 from mental health. The group comprised of the following professionals: three clinical psychologists, one child psychiatrist, three psychiatrists, three medical social workers, nine family physicians and one internist. This unique project was developed through joint cooperation between the Israel Ministry of Health, the various Health Maintenance Organisations (HMO) and Tel Aviv University. The course was run in a didactic as well as in an experiential format in which there were mixed groups of mental health and primary care professionals working on common issues. Mixed Balint groups were also run weekly, and monthly visits to the alternative professional group members' workplaces took place. In addition, didactic teaching modules in the areas of primary care and mental health were delivered; emphasis was particularly placed on experiential learning which helped the two professional groups become aware of and get to know the other's professional culture. The Shiluv course had a very important long-term outcome in that it produced impressive leaders and positive role models in the area of psychosomatics, integrative primary medicine and mental health care.⁸ It was one of the facilitators and triggers for the creation of an integrative counselling clinic for frequent attenders and somatisation patients that is well documented in the international literature.⁹⁻¹¹

Balint groups

An innovative method for facilitating cooperation between mental health professionals and primary care specialists is through their participation in regular Balint groups.^{12,13,14} Balint groups have been found to improve communication skills and help sensitise participants to their own psychological processes.¹⁵ They have been found to improve doctors' perceptions of their patients' problems, improving interpersonal skills and helping doctors help them in their understanding of their own emotional psyche.^{16,17} They may also improve the psychological condition of burnout where group members, in the context of a supportive atmosphere, present cases relating to their work.¹⁸⁻²¹ The discussions help the understanding of the doctor-patient relationship and patients' reactions, as well as sensitising doctors to their own feelings and motivations.²²

Balint's method, with its emphasis on the role of psychology in medical care and on the interpersonal relations between the group members and their patients, can be seen as a good way to address communication issues in health care, including primary care.^{23,24} Balint groups help doctors take the initiative in their work, empowering them in their professional lives, in coming to terms with uncertainty and sometimes even in knowing that there are no clear answers or solutions.²⁵ Here doctors are sensitised to understand patient, as well as disease issues. Long-term Balint exposure may help doctors become more coherent and meaningful in dealing with their professional lives. The group encourages the physician to listen to the patients' narrative, instead of using only the traditional style of medical history taking.

Balint groups have generally been run for family physicians, including primary care doctors, but they often include mental health specialists as well. Balint groups do not deal with medical diagnosis, or with professional methods of treatment. They aim to understand more profoundly the relationship between the doctor (the presenter) and the patient (the presented case), and often in addition between the presenter and other professionals, including the mental health professional in the group. The focus of the group discussion, then, is partly about the personality, the situation and the background of the patient (the presented case); and partly about the doctor (the presenter) and his or her emotions and personal determinants. As a result, the interpersonal relationship between the doctor and patient (and the family) may become clearer. Having experience in a Balint group allows the doctor to become a better physician for all health problems, but especially for mental health. It helps to make the doctor become a better cooperator, a better partner in shared care of patients with psychological or psychiatric disorders.

In comparing Balint groups in Israel with the original groups of Michael Balint as described in his books, it was found that Israeli Balint groups were more supportive and gave the participants more guidance, with few interpretations (Hakim, personal correspondence, 2009). This finding can be explained by the fact that Balint leaders today are not exclusively embedded in the psychoanalytical approach.

Establishing a Balint group in a primary care clinic

In a small town in the south of Israel the HMO chief and the consulting psychiatrist decided to arrange a

Balint group. The initiative came from the primary care physician who noted that many of her doctors were burned out. For the psychiatrist, the formation of such a group was a good opportunity to broaden the scope of his consultation work with primary physicians. The group leaders were the consultant psychiatrist and a specially invited clinical psychologist from the same mental health team. The majority of the members of this group were primary care doctors who came from the former Soviet Union, who generally knew one another.

The group met every two weeks, for a period of half a year. They sat in a circle, which physically encouraged intimacy and allowed the group to informally and spontaneously present their problematic cases. One of the challenges for the leaders was to run a group whose members worked together in the same 'organic' unit. In reality, this turned out to be a culturally different experience in which the members learned to cooperate with one another within an atmosphere of emotional exposure and sharing. At a feedback session, they remarked that they had learned much from the open dialogue and varying viewpoints of different disciplines within the group setting. This allowed them to openly see the 'hidden secrets of the professions' and gave legitimacy for them, too, to be become more open and expressive of their own professional secrets.

The establishment of such a group in a circle, where the doctors sat together discussing common issues in an empathic and supportive atmosphere, changed the work setting for doctors who usually sit for almost the whole day alone in their rooms, most often behind their desks and computers, receiving one patient after another. They are also used to working within the framework of a rigid professional and administrative hierarchy, getting instructions from their superiors. By contrast, in the group setting there was no hierarchy. Furthermore the two group leaders tried to be egalitarian – guiding, but not teaching.

A case vignette from an integrated Balint group

A 40-year-old family physician presented the following case to the group. The patient was an 84-year-old married woman, a retired primary care physician and mother of two. She and her husband were frequent and demanding attenders at the doctor's clinic. She suffered from vascular disease and had recently had an orthopaedic operation for a hip joint fracture. Since that operation, some minor

signs of mental deterioration had appeared but she refused to take a Mini Mental State Examination test (MMSE). The presenting doctor in the Balint group felt manipulated by the patient's family, who wanted him to recommend to the authorities that the patient's driving licence be taken away, and there was a constant struggle between the doctor, the patient and her family.

During the group discussion the focus was partly laid on the doctor, who complained of being incapable of diagnosing the patient's problem without the MMSE. This comment was addressed to a psychiatrist in the group. The two leaders spontaneously openly discussed this issue between themselves. Later on, the issue of the limitation of medical professional skills without 'our basic diagnostic instruments' was discussed. The focus was partly laid on the doctor: how difficult and how frightening it was for him to treat a colleague. This in itself eventually became a question for discussion, a diagnostic and therapeutic tool. The focus then moved back to the patient; she had lost her job and her status, she had suffered a frightening fracture and operation and was now afraid of 'becoming insane'. As a result of the discussion, the doctor-patient relationship changed, becoming less aggressive as a deeper understanding was gained. Consequently the presenter could attain a more accurate and more holistic diagnosis and the colleague/patient could be treated more appropriately. Furthermore, a mental health member of the group suggested a 'shared consultation' with a psychiatrist, a suggestion keenly taken up by the presenter.

Balint group leaders and shared care

In most Balint groups in Israel the leaders are a mix of primary care physicians and mental health professionals. The interaction of Balint leaders coming from different professional backgrounds may serve as an effective way for the group members to distinguish which is the best possible means of collaboration between a primary care physician and a mental health professional. This combination of leadership leads to open discussion, examining the issues presented from different vantage points. It often enriches the way the group sees the presented case and can lead to lively discussion and self-examination. In such a Balint group 'shared care' can be learned through both the personal and group experience. The group leaders help the presenter and other group members to combine their resources,

jointly working out and understanding the case presented. This may generate a new interdisciplinary and integrative perspective on the issues presented, charting a new course of action and relieving the presenter of the weight of overdue emotional involvement.

For the leaders to be effective in their leadership styles they should be flexible, seeking out different possibilities and choices where dogmatic adherence to specific professional ideologies may be construed as being neither productive nor effective. Exclusive psychoanalytic knowledge and interpretations may be replaced by inventiveness, innovation, spontaneity and openness. In this way, intervention by the leaders and group members may become a creative interaction.

Balint groups are supervision groups. Yet the leaders of these groups should try, as much as possible, to act in an egalitarian manner where they do not take on a superior stance, and do not convey to the members that they have all the answers. They should rather guide the group or the presenter to reach their own conclusion to the dilemma raised.

Challenges in forming these groups and making them work should also be addressed. These include when these groups should be run (e.g. after hours or during working time)? In the latter case, organisational issues such as the time taken and its cost for the organisation should be considered. Also, the venue where these groups should take place is important, as this should provide the appropriate ambiance for effective group discussion.

Balint groups as an 'adult playground'

In Balint activity, the group itself may be seen as an area for adult play, a playground in which the leaders create a safe and consistent system for experimentation and interdisciplinary cooperation. By leaders encouraging 'playing' in groups, the members can feel free to be able to make appropriate choices and express mistakes. The space for playing therefore serves as a therapeutic function, a place for potential experimenting and exploring new innovations and possibilities within the clinician-patient relationship, as well as the member-group-leader interface. Playfulness in Balint encounters may also encourage intimacy and group cohesion. This 'group space' should be open, non-threatening and supportive, enabling the presenter and the group to reflect and develop, through play and experimentation, questioning often rigid internal structures.

Conclusion

Balint groups can be perceived as an effective forum for both primary care doctors and mental health professionals through which a special understanding and dialogue between the two professions can develop. This can be seen as an important and innovative platform for 'shared care'. Leaders of Balint groups themselves often come from different disciplines which can also both enrich and challenge Balint activity. The leaders can serve as appropriate role models in the ongoing interdisciplinary, experiential learning experience.

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CONFLICTS OF INTEREST

None.

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