

Review Article

The Experience of Balint Groups in Spain: A Personal View

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ABSTRACT

Balint groups (BG) are an effective learning method in care practice used by the general practitioners (GP) concerning the psychological aspects of their work with patients. Despite the importance of the expansion of Balint groups worldwide, they never established equally in every part of the planet. This report aims to offer a brief historical outline of the significance of BG in Spain, from their inception until the present time. Its author intends to analyse the possible determinants in the disappearance of BG in Spain. Biotechnocracy, health as part of the consumer market and care pressure are considered some of the potential factors involved. Given the dehumanisation of medicine and psychiatry, the overwork of professionals and the irrational use of medical resources with the subsequent economic cost it represents for all countries, the Balint methodology has become more necessary than ever. It can therefore be concluded that to preserve the BG in care practice the said practice must adapt to the current social and medical changes. Changes must be made in the classic technique used by the BG, awareness must be raised in health institutions of their importance in quality improvement and care management, and teachers' commitment must increase in primary care and psychiatry residence programmes as regards the psychosocial aspects of the doctor-patient relationship.

MeSh Headings/ Key words: Balint groups; Spain; Primary care; Psychiatry; Reflective practice

Introduction

We owe Michael Balint, a Hungarian biochemist, psychiatrist and psychoanalyst, the creation of Balint groups (BG) and the relevance of devoting attention to the psychological aspects in doctor-patient relationships. Balint was a professional who, in the light of the remarkable development of science and the prevailing biomedical model in the middle of the 20th century, was able to find a place for psychoanalysis within medicine.

In 1948, he started the BG in Tavistock Clinic alongside his wife Enid and some care workers. Later on, in the fifties, he started to spread his method in medical education and disseminate it in all the contexts in which a doctor-patient relationship existed [1]. The strongest presence of BG and of his perspective was in the trade of general practitioners. However, the fact that models shifted from disease-centred models to more holistic ones, in which the patient is also taken into account [2,3] and, especially, their environment (biopsychosocial approach) [4,5] made the BG end up spreading to other disciplines, such as nursing and care work.

Nowadays, we live in a social scene in which medicine and mental health are losing so essential elements as the subjectivity in a call with people who ask for help, or the fact of many professionals enduring overwork caused by care pressure, which makes them more prone to suffer from burnout, with its subsequent repercussions in patient care. On account of the current situation, the Balint methodology remains more relevant than ever.

In Spain, the BG tried to be implemented in primary care teams in public healthcare in the sixties. After some years of success, they started to gradually disappear until today, when their presence is scarce in the country and they have been devalued as far as their essence is concerned. This report explicates the evolution of BG since their introduction in Spain, the reasons that may have led to their partial disappearance, and finally, some technical adaptations about their methodology suggested in order to maintain their presence nowadays.

4. Past and present of the BG in Spain

A promising beginning

In Spain, the first BG ever known date back to the sixties. Some of the psychoanalysts responsible for the introduction of psychoanalysis in Spain, like Dr. Pere Bofill and Dr. Pere Folch, made their first attempts and had their first experiences with physicians. Dr. Josep Beà, psychoanalyst and psychiatrist, was perhaps the first to start up a BG in Hospital de la Santa Creu and Hospital de Sant Pau in Barcelona, and possibly he became a pioneer in all of Spain [6].

In the seventies, the BG began taking shape in terms of technique and structure in Barcelona, Madrid, Valencia and the Basque Country, and they tried to be introduced in national training programmes for the speciality of family medicine. In order to achieve that, Jorge Tizón, one of the psychiatrists who has developed more deeply the Balint methodology on both a theoretical and a practical level, and the psychological aspects in the doctor-patient relationship [7], even contacted Enid Balint and the Balint International Society [8]. With Tizón and other psychoanalysts, the speed at which they wanted this methodology to be popularised and implemented in care practice was greater than the handling capacity of those who were going to form and manage the BG. The professionals were not prepared well enough. This led to a series of failures, de-idealisations and institutional problems which halted their propagation.

Rise of the BGs

The failure of the BG in the seventies triggered numerous reconsiderations about them concerning their technique, objectives and assessment methods, which brought about the formation of other groups called "Balint-like" (Footnote 1) or "reflection groups" [6,9]. As a result, their growth was slower and more moderate, albeit more stable [10]. This much better thought-out approach possibly allowed, in the eighties and the nineties, the Balint methodology to be recognised and implemented in family medicine residence training programmes. It was the necessity and the interest of the first graduates in this speciality to receive training in the psychic and relational aspects, both of them seen as fundamental elements in care practice, that made the BG consolidate in Spain. In those times academic training was rather oriented to the biological aspects.

International psychiatrist José Guimón was one of the physicians who most endeavoured to the application of the Balint methodology and group practice to public medical care, and to the training of psychiatrists and family doctors. Halfway through the eighties, "Balint-like" groups became institutionalised in the teaching units of some hospitals, and especially, in primary care centres. Care practice reflection groups thereby started to emerge in the training programmes of residents taking the specialities of family medicine, nursing, and psychiatry. They even appeared in the undergraduate programmes in medicine and social care in the shape of "psychological awareness groups" [11] in care. All of these groups will preserve the essence of the Balint methodology, except for a few adaptations in respect to the traditional BG.

Initially, the BG were 90-minute weekly meetings held in one year, then they became fortnightly, and currently, depending on the national teaching units, a total of 16 meetings or less is held, and they last approximately one hour. Despite the BG beginning to be implemented in national training programmes, their criteria were never homogeneous, and thus, every teaching unit was able to define their own.

The BG in the present time

Since the late nineties until now new programmes have been created across the country in which mental health specialists offer support, advice and care in situ to primary care outpatient teams [12]. In these "advice and connection" programmes [13] psychiatrists and psychologists teach, do case monitoring, interconsultations and analyse patient referrals to outpatient mental health centres.

It is in contexts such as those in which, in this day and age, some "Balint-like" groups in care practice still survive. They normally consist of fortnightly or monthly one-hour sessions of non-compulsory attendance, throughout limited periods of time with doctors, nurses and social workers. Attendance tends to be uneven, as this service is continually affected by the frenetic activity of primary care centres (calls, emergencies, delays in daily consultations prior to the BG assistance...). The group leader adopts a psichopedagogical and proactive attitude, and strikes up conversation about common topics and conflicts related to the relationship of professionals with patients, families and, despite that being trickier, also with the team and the institution. With time, some members of the group will even be driven to present their own cases. "Free-floating discussion" (Footnote 2) is stimulated, and the group members' contributions are not interpreted individually.

Factors involved in the disappearance of the BG

In the last fifteen years, the social and medical changes which have taken place have affected the clinicians and the relationship between doctors and their patients. Especially, it is imperative to mention the global financial crisis in 2008, which not only caused a decrease in public expenditure on the healthcare system, but also hit the quality of the services and the roles and functions of the healthcare personnel [14]. Below we present a series of factors which might have been responsible for the gradual disappearance of the BG in Spain [15]:

a. Biotechnocracy and loss of subjectivity. What used to be the basic technology of general practitioners (the clinical interview and the doctor-patient relationship) has now transformed into a computer which often stands, both literally and metaphorically, between the professional and the patient. The great biotechnological advances exclude human subjectivity in search of a scientific method "which can do everything" and is never wrong. The doctor is always expected to have an answer for everything, and the patient always expects their demands to be satisfied in the best possible way. For the healthcare system, this translates to high levels of demand, in which medical responses must be immediate, effective and specific. What is then the point of BG in an activity in which people increasingly expect only immediate solutions, and neither uncertainty nor waiting are tolerated?

b. Care pressure and the lack of time "to feel and think". In Spain, general practitioners only have between 7 and 10 minutes to see 40 patients per day on average. Doctors in a comparable U.S. setting see 10 to 20 patients per day. So relentless is the care pressure and so little time do they have to handle it that physicians get burnt out and, as a result, they even forget to breath and ask for a calm period which helps them get rid of all the anxiety and suffering which take over them. The little time available to reflect, and the necessity to be constantly seeing patients no matter what made that the BG started to be tagged as unnecessary, or even considered a luxury, something that did not solve the immediate problems of the patients, and nor did countertransferentially solve those of the professionals, obviously. The author of this report does not come to imply that Spanish physicians do not show any interest in communicating, or sharing their feelings of, for instance, impotency, frustration or need for help. Their mental oversaturation provokes they cannot even consider doing so. They do not have time to reflect, and medical institutions do not facilitate that either, as it may even be of some interest to them that doctors do not think much. In Spain, it seems the lack of reflection and the bureaucratisation of medical practice have become institutionalised [16].

c. Health as part of the consumer market. A consumerist society, which turns medicine into another object of consumption,

where many aspects of life are medicalised [17], and an irrational use of medication is made. Hospitals and healthcare centres are true companies conceived as productivity units. They are companies that reward and motivate professionals able to generate shorter waiting lists, and do not commit to the patients. Finally, political and economic considerations take precedence in defining treatments rather than the medical needs and the provision of a high-quality care.

d. The little teaching commitment in psychosocial aspects of the care. Current medical training still remains centred in the acquisition of biotechnical and clinical knowledge from an intellectual perspective, thus increasingly less holistic, which neglects the personal skills (empathy, tolerance, introspection, sensitiveness, availability...) of the professionals when giving assistance to their patients. This is due to a complex scheme of variables in which a sociocultural context increasingly more dehumanised and a more biotechnical medicine influence condition the profile of the professional they want. Although health professionals training is positively valued in terms of the psychosocial aspects of the therapist-patient relationship, in practice, the society will generally keep placing the emphasis upon the intelligence quotient and the qualifications of its physicians rather than upon the assistance provided.

Learning is a mixed process, both cognitive and emotional. Medical training should be sustained on the capacity to reflect, to think before acting whilst paying attention not only to the theoretical elements but also to the emotional ones. This would ameliorate the state of clinicians' health, as they would maintain a balance between their personal and their professional functions, avoid burnout and make a more rational use of medical resources [18]. Currently very few undergraduate and postgraduate education programmes include "Balint-like" spaces within their training plans. In Spain, the conceptual model in the medical degree is still too focused on the disease, that is, from a very scientific-technical point of view. This entails that residents who partake in a "Balint-like" group for the first time find it hard to increase their knowledge when this is different from their previous conceptual models. At present, there are very few resident doctors specialised in family medicine who will know what a BG is. That said, it is all the more worrying, though, that many psychiatry and psychology residents have not heard of the BG, or of their author.

e. The non-adaptability of the Balint methodology to the present. Some orthodoxy and a strict psychoanalytical monitoring in traditional BG did not facilitate that the groups adapted to the needs of the consultants and to the reality of the time. The first BG in Spain were highly detrimental. An indiscriminate use of individual transferential interpretation in general practitioners, who had to endure fragility and emotional sensitiveness due to their workload and the suffering they witnessed, was regarded as being persecuting and careless. Many doctors ignored what the task of the group was, as they had not been told about "the rules of the game". Many others, again persecuted, felt they were being "psychoanalysed" by their group leader. From a classic neutrality and psychoanalytical absence, they did not feel the leader was empathetically connecting with them, and offered no answer to their questions, not even to aspects related to the workings of the group.

The BG asked for commitment, punctuality and regular attendance, and all that started to drop and disappear. The doctors would arrive late to the meetings or not attend to them at all because they were seeing patients in the surgery. It must be stressed, on the other hand, that the institutions (director and resident tutors) did not provide a space in the professionals' agenda "free of patient calls" in order that they could join the BG. Such continuous and variable lack of participants constantly affected the external setting and even the narcissism of the group's conductor, who saw time and again their group cohesion weaken.

Shifting from disease-centred models to biopsychosocial models underlined the need for including other medical disciplines both in care practice and in the BG. This made many group conductors plunge into confusion in their internal setting, as they did not know how to properly handle the new group dynamics which took place when other disciplines were incorporated, especially nursing and social care.

Renew or die to ensure the continuity of the BG

Supporting Balint does not imply turning our back on reality and the area in which we are working. This must be borne in mind if we want to give continuity to his methodology in our healthcare system. However, with so many social and medical changes, what modifications are we willing to make, and what should we renounce?

In a social and medical panorama with increasingly more emotional confusion and depersonalisation, the users need clear references which initially will need to be cognitive. To expect that in the first sessions of a BG the participants behave actively and enthusiastically, freely associating ideas after having presented a case is asking the impossible. To begin with, because professionals neither know how BG work nor seek help in them. We have to go meet them clearly explaining what the meetings consist of, their scope and provide them with answers. It may be advisable to start the BG by developing, from a theoretical viewpoint, several recurring topics or contents about clinical problematic situations in daily care practice. Organising the group meeting structured in modules (communication skills in medical interviews, frequent problems related to the patient and their family, teaming, and handling strategies...) could also be beneficial. In addition, some questions could be asked to spark discussion, of the sort: "what motivations exist in the medical vocation?"

Most of the professionals are exhausted, and thus it is important that, despite their tiredness, they can "have fun". Hence, to "play", in the most colloquial and psychoanalytical sense of the expression, communication and creativity of thinking, it is recommendable that some psychodramatic techniques be used, as well as, role playing, sculpture work and so on throughout the more "cognitive" modules. Using the sculpture work method in a couple and family therapy allows discovering tensions, conflicts thought to be latent, and, overall,

facilitates emotional expression. This way, we keep gradually advancing towards an emotional learning.

At this point, what we hope to have achieved is a group atmosphere devoid of strictness, and comfortable, which enables the participants to rely on the group and its leader. If no more than a few meetings are possible, we will have to assume there is nothing else that can be done but to try to raise awareness among the professionals of the psychological aspects of care practice. If more meetings can be held, and a friendly group atmosphere is created, the active role of the leader will keep losing its importance, which will favour more group exchanges less influenced by the topic raised, and thus more personal and profound, in which theoretical considerations will start being of little weight [19,20].

From the author's standpoint, what must be achieved is to have an intimate and calm forum, where the professionals' emotions can be shown evoked by the voice of their own patients, and so they feel connected with them. If we should, in order to do so, renounce part of the neutrality and analytical abstinence, and embrace new techniques from models different from the psychodynamic one, then so be it. Trying to preserve the essence of the classic BG ought not to be incompatible with a little of technical eclecticism (Footnote 3).

Finally, in a time when medical authorities are increasingly being asked for documented demonstrations about the effectiveness and usefulness of the therapeutic practices employed, the BG cannot be left behind. Currently, there are very few international qualitative and quantitative pieces of research on the efficacy of the BG in professionals [21]. The main existing studies are qualitative and deal with professionals' work satisfaction, burnout prevention [22] and improvement of competences with psychosomatic patients [23,24].

There is a lack of empirical studies which cast some light on the reduction of the pharmaceutical expenditure, the doctors' work leaves, or the poor use of medical resources by professionals partaking in a BG. Conducting studies with more "administrative" or "management" aims would help the BG to be more often taken into consideration by medical authorities.

Brief concluding remarks

In spite of the interest of many psychoanalysts in the introduction of BG, on comparing ourselves with more technologically developed countries, it can be observed that in Spain their influence has been rather subtle. Notwithstanding that this report is loosely related to this topic, it must be said that there are hitherto no association-like institutions or members affiliated with any kind of European or American federation.

Presently, despite possessing more coherent Balint methodologies with the present time, and despite having attempted to introduce exchange and reflection spaces regarding care practice for professionals in primary care and mental health, it appears that the Spanish medical authorities have very little interest in that. The predominance of the biomedical paradigm and the commercialisation of medical problems are two factors that may explain this fact. Doubtfully, the author also sustains there might be some reluctance to the application of the Balint method due to its classical origin in psychoanalysis (Footnote 4).

Hopefully this report has been able to reflect the experience of the BG in Spain, and the obstacles they had to surmount to be present in a sociocultural reality which does not favour their continuity yet needs them more than ever.

Conflict of interest

None declared

References

1. Balint M. The Doctor, his Patient, and the Illness. London: Pitman Medical, 1957.
2. Balint E. The possibilities of patient-centred medicine. *J R Coll Gen Pract.* 1969; 17: 269-276.
3. Bardes CL. Defining "patient-centred medicine". *N Engl J Med.* 2012; 366: 782-783.
4. Havelka M, Lucanin JD, Lucanin D. Biopsychosocial model-the integrated approach to health and disease. *Coll Antropol.* 2009; 33: 303-310
5. Pawlikowska T, Leach J, Lavallee P. Consultation Models. In: Charlton R. Learning to Consult. 2007; 178-215.
6. Tizón JL. Los grupos de reflexión en atención primaria de salud. *Aten Primaria*. 1993; 11: 69-72.
7. Tizón JL. Componentes psicológicos de la práctica médica. Barcelona: Biblária. 1996.
8. The International Balint Federation.
9. Arillo A, Zabalegui MJ, Ayarra M. El grupo de reflexión como una herramienta para mejorar la satisfacción y desarrollar la capacidad introspectiva de los profesionales sanitarios. *Aten Primaria* 2009; 41: 688-694.
10. Tizón JL. Sobre los grupos Balint, el movimiento balint y el cuidado de la relación médico-paciente. *Aten Primaria*. 2005; 36: 453-555.
11. Totorika K, Eguíluz I, González Torres MA, et al. La sensibilización psicológica en el pregrado de medicina. *Avances en Salud Mental Relacional.* 2003; 2: 1-10.
12. Ribé JM, Fleitas E, Pares J. Un programa de colaboración con la Atención Primaria y sus debilidades: la realidad y la modestia. *Norte de Salud Mental.* 2010; 8: 45-54.
13. Gask L, Sibbald B, Cree F. Evaluating models of working at the interface between mental health services and primary care. *Br J Psychiatry*. 1997; 170: 6-11.
14. Notara V, Koulouridis K, Violatzis A, et al. Economic crisis and health. The role of health care professionals. *Health Sci J.* 2013; 7: 149-154.
15. Ribé JM. Qué fue de los tradicionales grupos Balint? en defensa de la perspectiva Balint y una metodología adaptada en los espacios de coordinación con atención primaria". *Norte de Salud Mental* 2012; 10: 13-27.
16. Burton L, Launer J. Supervision and support in primary care. 2003.

17. Maturo A. Medicalization: current concept and future directions in a bionic society. *Mens Sana Monogr*. 2012; 10: 122-133.

18. Tizón J. Sobre la formación integral del médico: aportaciones de las Primeras Jornadas Estatales de estudio y reflexión sobre el médico. *Educ Med* 2009; 12: 209-222.

19. Ribé JM. De la emoción a la razón a través del grupoanálisis. *Norte de Salud Mental.* 2012; 10: 13-27.

20. Norcross C, Goldfried M. Handbook of Psychotherapy Integration. 2005.

21. Van Roy K, Vanheule S, Inslegers R. Research on Balint groups: A literature review. *Patient Educ Couns*. 2015; 98: 685-694.

22. Kjeldmand D, Holmström I. Balint groups as a means to increase job satisfaction and prevent burnout among general practitioners. *Ann Fam Med.* 2008; 6: 138-145.

23. Fritzsche K, Scheib P, Ko N, Wirsching M, Kuhnert A, Hick J, et al. Results of a psychosomatic training program in China, Vietnam and Laos. *Biopsychosoc Med* 2012; 6: 17.

24. Shedler J. The efficacy of psychodynamic psychotherapy. *Am Psychol* 2010; 65: 98-109.

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FootNotes

1. Balint-like groups, also known as Balint-style groups, is the name used to refer to any non-classical groups inspired by the Balint methodology.

2. The equivalent for *free association* in group dynamics.

3. In regard to integration, in psychotherapy, *technical eclecticism* is a method which focuses on the selection of psychotherapeutic techniques regardless of the theory they were conceived in [20].

4. Medical policies adhere to the guidelines established by the mental health models based on scientific evidence. Psychoanalysis might still be far from this model despite the fact some serious empirical studies which show the effectiveness of psychodynamic therapy have started to appear [24].