Parker, V. (2022). My Experience of Facilitating a Balint Group for GPs and its Interface with Supervision, 2009. *Journal of the Balint Society, 49: 109-122.*

JOURNAL OF THE BALINT SOCIETY, VOLUME 49, 2022

My Experience of Facilitating a Balint Group for GPs and Its Interface with Supervision (2009)

Valerie Parker[1]

[1] Primary care counsellor

Ever since I began working as a Primary Care Counsellor I have been fascinated by how the relationships between GPs and their patients effect medical consultations. I was therefore very interested when a GP asked for my help in exploring his inexplicable anxiety about his work. During our discussion we realised that much of his concern focused not on worries about individual patients, but on his struggles with time-keeping. We began to wonder how this impacted on his relationships, with his patients, and how his ability to assert himself varied according to the feelings evoked by individual patients. We also reflected on how firmer boundary-keeping might change these relationships.

Following our discussion, I was invited to run a workshop on boundaries and timekeeping for all the staff at the surgery. The issues that emerged were fascinating. We began to think about the power some patients have to elongate appointments or receive special attention, while other patients seem to be almost apologetic about having any time. We also reflected on how individual patients deal with their annoyance and frustration at being kept waiting and how this might affect their relationship with the doctor and the surgery. One of the GPs at the workshop was enthusiastic to develop the ideas further, and he asked me if I would be interested in setting up and facilitating a `Balint'-type group with local GPs.

This was a great opportunity for me to develop my interest in the dynamics of the doctor/patient relationship and to experience leading a group, but I was apprehensive about what the doctors would be expecting. What is a Balint Group? Was this to be a supervision group, or merely a discussion group? How assertive should I be as a leader? I began to research information on Balint Groups, joined the Balint Society, and decided to enroll on a counselling Supervision Course with 'Counsellors in Primary Care', which I hoped would help me with the supervisory aspects of the work and its context in Primary Care. One of my concerns involved

---

[1] First published 2009, Vol. 37, *Journal of the Balint Society*.

the problem of language and culture. I was aware that although GPs might be attending such a group to increase their reflective and psychological awareness, there is an inevitable cultural divide between the medical paradigm of diagnosis and cure and the more reflective psychological search for meaning in illness. I was conscious that while the doctors were hoping to open up their awareness and ways of thinking, it was important to be sensitive to their differing attitudes; developing and encouraging mutual respect would create an opportunity for growth and learning for us all.

Although I have always enjoyed working with GPs, I have also been conscious of some deeply embedded transference responses which could affect my confidence as a leader. The underlying danger is that my sense of awe, combined with a tendency to undermine my own ability and expertise when I feel under pressure, may either make me anxiously over-controlling and dominant, or too self-effacing and unable to assert a sense of leadership. When I explored these feelings I realised that the underlying dynamics in my relationship with my younger sister, who is a GP, probably affects my attitude to all doctors. I have always had a sense that her profession is more highly regarded in my family; in addition my sister and I have a tendency to be both over identified and competitive in our relationship with one another. It has been helpful to reflect on this and begin to clarify the effect that some of these unconscious projections may have on my relationship with the doctors.

In order to better understand the origin and context of Balint Groups, I read Michael Balint's seminal book *The Doctor, His Patient and the Illness* (1957) in which he describes his work with groups of doctors at the Tavistock Clinic in the early 1950s. These groups were established by Balint to investigate the relationships between patients and their doctors and to help the doctors develop more effective skills in understanding and relating to their patients. `Balint Groups', as they became known, usually comprised 10-12 'family doctors' and one or two facilitators

and met weekly for a period of several years. The doctors were encouraged to present cases which they considered problematic or uncomfortable or provoked an unusual amount of frustration. They would discuss their reactions and insights, and reflect on what they felt was happening unconsciously in these relationships, with the aim that this might help them to understand their patients better. In the words of Balint: 'Our aim is to help the doctors to become more sensitive to what is going on, consciously or unconsciously, in the patient's mind when the doctor and patient are together.'

I realised that in many ways a Balint Group is similar to a supervision group for counsellors — it provides the GPs with support, an opportunity to share problems and concerns, and helps them to think about their work in a new way. So how might such a group compare to a supervision group, and how would this affect my role as its facilitator? Hawkins and Shohet (2006) cite three main functions of supervision —developmental, resourcing and qualitative. Their definition of the developmental aspect of supervision relates very closely to the aims of a Balint Group. To help a supervisee:

- understand the client (patient) better
- become more aware of their own reactions and responses to the client
- understand the dynamics of how they and their client were interacting
- look at how they intervened and the consequences of their interventions
- explore other ways of working with this and other similar client situations.

Hawkins and Shohet describe Resourcing as the process of supporting supervisees through the emotional stresses of their work. This would not be an overt aim of a Balint Group, although understanding the unconscious effects of their interactions with patients, and feeling supported by their colleagues may help doctors cope better with the stresses of their profession. The Qualitative function of supervision refers to the supervisor's responsibility for the work of their

supervisees. This does not apply to Balint Groups in which the doctors remain individually accountable for their work.

Another important comparison with supervision involves the behaviour and involvement of the group leader. It is generally agreed that there is a very strong didactic element to counselling supervision (Kadushin 1976, Proctor 2000). Onso (1985) even considers teaching to be 'the primary function' of supervision. In the context of a doctors' group however, I believe teaching is inappropriate; it is important to stand back and allow any learning to evolve naturally through discussion and observation. This is strongly endorsed by Enid Balint et al (1993): 'The psychoanalyst is there as a facilitator — an opener of doors — not as an instructor.'

The concept of the leader as a support rather than a proactive manager or director is respectful, and reinforces the importance of allowing the GPs to maintain a sense of their own expertise. Gosling (1996) emphasises the importance of respecting the unfolding process: `Using the Balint Method every effort was made to reinforce the GPs' authority in what they did or didn't do so that they would adopt new ways learned in the group only to the extent that they themselves found them useful in the light of experience.'

I have found it helpful to think of the group as a co-operative learning experience, much like Proctor's (2000) Co-operative Group Supervision model, in which the leader's most important function is predominantly to facilitate the group process. This involves containing the group and its members through the challenges and stresses of becoming a lively, functioning and collaborative entity. Tuckman's (1965) definitions of the stages of group development, *Forming, Storming, Norming and Performing*, have been a helpful guide to the unfolding process.

Forming

The primary task in the early stages of any group is to establish a solid framework or a *Group Working Agreement* (Proctor, 2000). From the very beginning it is fundamentally important that the leader or supervisor can manage the group confidently and firmly through this process. This includes establishing boundaries for time management, confidentiality and presenting behaviour and, in doing so, clarifying a firm sense of holding and containment. Bearing in mind my underlying concerns, I was aware that the task of establishing a clear position as leader, balancing assertiveness with openness and respect, was going to be challenging.

Before the real work of the group began, the GP who helped to set up the group called a preliminary meeting to discuss our ideas and to set out a proposal. I felt that it was important from the outset that I took administrative control, allowing Dr A to hand over responsibility and become a member alongside his colleagues. Ten GPs attended this meeting, all of whom decided to come to our first group. We established that I would be responsible for all communications, for the time keeping during the meetings, and for booking the venue. We planned to meet once a month for 90 minutes. I anticipated that this relative infrequency would make it difficult to establish a sense of unity and coherence in the group. During the early months several doctors decided to discontinue, and it took several months to establish a regular group. This concerned me, feeding into my own lack of confidence about my ability as leader. It was important to appreciate the insecurities present for every member of a group, and to realise the value of being proactive in managing boundaries and helping to establish a sense of safety for everyone.

The task of containment also includes managing external disturbances to the boundaries and I have realised that at these difficult moments it is helpful to make links with what is happening in the group as a way of refocusing attention. I recently had the experience of co-leading a short-term group at a Balint Society

conference, and in our first session we were interrupted by several very annoying and uncomfortable intrusions. At one point a porter urgently came in requesting keys. Several members of the group were very angry, and it was clear that it would take some time to settle. I noticed how this disruption mirrored both the cases that we had been discussing that morning, in which someone had stood in the way of the relationship between a doctor and his patient. By making a link between these experiences, I was able to help the group refocus and return to their task with greater ease.

Storming

During the early stages of group life it is usual for the members to be preoccupied with trying to find a balance between individuality and belonging (Proctor 2000). This is a challenging time; all the members will be testing the boundaries and trying to establish their own place in the group. Proctor suggests that participants will be primarily concerned with issues involving *'difference, competency and hierarchy'* — who speaks the most; who is the most insightful, and how to gain respect. The insecurity and anxiety present at this stage of the group was particularly demonstrated by Dr B. At the end of our second session, he took me to one side and said that he was worried about whether we would expect him to present a case at our next meeting. He explained that he was off work on long term sick leave but that only two members of the group knew this. I said that I thought his personal experience would be valuable to the group and I hoped that he would feel able to talk about this next time. The next day I received an email from him expressing his apprehension about presenting to the group when he is currently not seeing patients and asking for my clarification about how he could approach such a discussion.

My reply was as follows:

> Firstly, I really appreciate that you are braving coming to the group, and I think that when and if you feel ready to share some of your experience, it will be very enriching for everyone, and will only serve to deepen the relevance of the group. I hope that you are able to talk to us at the next meeting and I would suggest that you don't prepare anything. We have not formalised what we present and this will develop and emerge as the group matures. However, beginning to look at the emotional impact and stress of your work on your life and reflecting on how your patterns of relating have affected your work would be extremely relevant. Starting to open up in this way will encourage everyone to look deeper at the inter-personal dynamics of their work and could be really helpful. It is important that we keep appropriate boundaries so that it does not become a 'therapy group', but as facilitator I can keep an eye on this.
> I think it was right that we did not speak on the phone, as contact about the group outside it should be kept to a minimum to ensure safety and confidentiality. If you agree and feel comfortable, then perhaps we should share our communication with the others, so that there is no danger of 'splitting' the relationships within the group.
> I hope this helps. V

This exchange brought up some very important points. Firstly, it allowed me to establish my role as a guide to the appropriateness of the material — encouraging the GPs to open up to their personal experience, but ensuring that this is relevant and contained. It was also an opportunity for me to clarify boundaries about safety, confidentiality and openness within the group.

I was fully expecting that Dr B would now have the courage to open up to the group at our next meeting. What I did not anticipate was that I would fall ill and would be unable to attend. This presented another challenge about contracting. We had made no provision for my absence. In the event I rang Dr A, who decided to cancel the session, but two doctors missed his communication and did in fact turn up. This prompted me to reaffirm our arrangements and to circulate a list of personal telephone numbers. I have realised that throughout the life of a group boundaries need to be continually reaffirmed and reinforced. It seems to be a question of negotiating a delicate balance between containing frustration, anxiety and discomfort and interpreting and challenging, while maintaining an awareness of what is happening in the group and how this might be reflecting the dynamics of the patient/doctor relationship.

The following month I turned up to the meeting anticipating that Dr B would now speak, and was disconcerted when he did not volunteer to do so.

Reflecting afterwards I was unsure how to proceed — should I leave it, ignoring our correspondence, and wait for him to find his own time, or should I confront him? I decided to telephone him the following day and he agreed to open up to the group at our next meeting. I wondered afterwards whether this intervention could be considered a boundary violation, and whether I should have let the situation unfold naturally. On the other hand it modelled an approach of facing emotional challenges, and it was important to ensure that Dr B became a full member of the group, which could not happen until he had participated fully. Ignoring the situation may have reinforced this split. As Proctor (2000) writes:

> Collective energy is released when supervisees, with the help of a facilitative supervisor, can sufficiently acknowledge and respect their own, and other group members' needs for identity. By experiencing themselves as included and including; sufficiently influential and acknowledged; clear where they stand; acceptant of differences and of strengths and shortcomings, members can work freely, purposefully and creatively — at least from time to time.

Norming

As we all began to grow in confidence, I was able to be less proactive and develop a clearer perspective on the group as a whole. I began to notice the phenomenon of 'Parallel Process' —when the group dynamics seem to be unconsciously reflecting the material being discussed. It is often difficult to observe because I can also become a participant. I am learning to notice that when things feel confusing, or when I feel under pressure and unable to think, it might indicate such unconscious processes.

Dr B's presentation gave us all the first really clear example of Parallel Process. His case concerned a patient whose enormous need became overwhelming and so difficult to contain that it began to impact on Dr B's health. The patient was a woman in her thirties with a rare and terminal brain disease. She suffered from multiple nervous problems and debilitating and untreatable pain. The case became especially worrying and complex when the patient discovered that she was 20

weeks pregnant. This caused huge dilemmas for the patient and the doctor. The patient desperately wanted a chance to have her own baby but Dr B felt caught in a terrible moral predicament. Medically, remaining pregnant was totally inadvisable for both the mother and the baby, but this woman was clinging to hope and it was painful to disappoint her so fundamentally. The patient decided to have a termination, which was medically complex and emotionally traumatic for her. Dr B increasingly struggled to draw clear professional boundaries, visiting her on his day off, giving out his personal phone number and even leaving a family gathering to take the patient to hospital.

As Dr B presented his case to the group, I noticed that the doctors began to reflect these difficulties in their emotional responses. When he complained about feeling unsupported and `dismissed' by his colleagues, the emotional atmosphere became increasingly stressed. It was as though the group were determined to show that they were not 'dismissive' — that they too would put themselves out as he had done. When I warned the group that we were approaching the time we had set for the next presentation, there was great resistance and a sense of urgency to help Dr B 'find answers' before we could move on. Dr C was particularly insistent, suggesting that we should forego the next presentation. The group seemed to readily agree. I felt uncomfortable and under pressure, realising that the doctors were reflecting Dr B's inability to draw effective boundaries; that they were being unconsciously seduced by Dr B's vulnerability, just as he had been by his patient. We were also modelling allowing ourselves to change our plans, which did not seem safe. Against the wishes of the group, I said that I felt strongly that we should give Dr D the space that we had allocated for her. Dr C was clearly angry with me, which felt uncomfortable, but I knew that maintaining group discipline at this moment was essential.

Although not explicitly expressed, the group was reflecting the powerful response that can be evoked by very needy and damaged patients, and I realised

afterwards how important it was to model an ability to contain this. This had been a big challenge for the group and to my role within it, but I think it was an important test of the group's resilience. Such situations are typical of this 'Storming' stage and are part of the growth and development of a strong, healthy and functioning group.

At our session the following month Dr D commented on my intervention, saying that she had been grateful to have been able to present her case. She also realised that the firm boundary keeping had been a helpful model. This was very affirming.

Performing

The group met five times before the summer break. Eventually four GPs left the original group — three clearly felt that it wasn't for them and the fourth could no longer make the time. We agreed that six members was too few, and invited one new GP to join us. Two members missed the final sessions before the summer due to sabbaticals, and so it was not until we resumed meetings in September that I began to feel that we were becoming a coherent group.

Despite two members being absent, there was clearly a different quality to the September meeting. I noticed that I felt more relaxed and confident, and it seemed much less urgent to impose a strict structure to the evening. For the first hour, the doctors reported back on their recent progress with patients whom we had discussed earlier in the year. Before the summer break, Dr E and Dr F had been encouraged by the group to resist some entrenched situations where patients had become over-reliant on them. Dr E was persuaded to try to break a cycle of dependency with an alcoholic patient, by using his imminent sabbatical as an opportunity to confront her and end the patient's reliance on very frequent consultations. Dr F decided that she would more assertively resist being sucked into a negative spiral of being persuaded by a patient to keep changing her

medication. In the September meeting both doctors reported back very positively and expressed surprise at the ease with which their patients accepted their stance when previously they had been so resistant. It was as though the pressure had disappeared. In the discussion that followed the GPs began to realise that the change in their own resolve, reinforced by the support from the group, had provoked a change in the patient's response. Dr D commented: 'It seems as though what we bring massively dictates how the patient responds.' There followed a discussion about whether the GPs bring their own needs into their consultations — perhaps a need to be relied on, to be empathic or particularly caring. They talked about handing out the tissues as 'doing the solemn "I care" thing' and were astonished to realise how much their attitude might affect the patient's behaviour.
I found myself able to sit back and observe their process of enquiry, reflection and understanding. It did not seem necessary to intervene or comment, and it was moving to observe the creativity that was beginning to emerge. Afterwards I wondered whether my own shift in perspective and deepening confidence in the group had influenced the unconscious group dynamics. Had my own development affected the group process, enabling me to subtly let go of my need to be recognised, so that I could allow things to proceed with their own momentum? I am mindful of Winnicott's wise words in *Playing and Reality* (1971):

> If only we can wait, the patient arrives at understanding creatively and with immense joy, and I now enjoy this joy more than I used to enjoy the sense of having been clever. I think I interpret mainly to let the patient know the limits of my understanding. The principle is that it is the patient and only the patient who has the answers.

As we approach the end of a year of work together, I am aware that this has been an enlightening journey for us all. It takes great courage for GPs to be prepared to open up to one another and reflect so deeply on their work and relationships. I have grown in confidence as a group facilitator during the year, and am learning the value of trusting the group process.

In these times of target setting and accountability, doctors are expected to cope, keep going and know the answers. Traditionally, cases are discussed briefly in the corridor or over coffee, and there is a culture of self-sufficiency and autonomous practice that does not encourage enquiry or exposure of vulnerability. As a result doctors develop ways of 'cutting off' (Burton and Launer 2003) by splitting their needs onto their patients and ignoring themselves, resulting in cases of burn-out and stress. Currently there is growing concern about the lack of provision and opportunity for reflective practice and support for GPs in Britain (Launer 2007). As a result Balint Groups seem to be undergoing a revival. It is a great privilege to be part of this process.

References

Balint, M. (1968). *The Basic Fault: Therapeutic Aspects of Regression*. Tavistock: London

Balint, M. (1957). *The Doctor, his Patient and the Illness.* Edinburgh: Churchill Livingstone.

Balint, E., Courtenay, M., Elder, A., Hull, S. and Julian, P. (1993). *The Doctor, the Patient, and the Group: Balint Revisited.* London: Routledge.

Burton, J. and Launer, J. (eds.) (2003). *Supervision and Support in Primary Care.* Abingdon: Radcliffe Medical Press.

Elder, A., Gosling, R., Stewart, H. (1996). *Michael Balint: Object Relations Pure and Applied.* London: Routledge

Hawkins, P. and Shohet, R. (2006). *Supervision in the Helping Professions.* Maidenhead: Open University Press.

Kadushin, A. (1992). *Supervision in Social Work.* New York: Columbia University Press.

Launer, J. (2007). Moving on from Balint: Embracing clinical supervision. *British Journal of General Practice*, 57: 182-183.

Onso, A. (1985). *The Quiet Profession.* Macmillan.

Proctor, B. (2000). *Group Supervision: A Guide to Creative Practice.* London: Sage.

Tuckman, B.W. (1965). 'Developmental Sequences in Small Groups.' *Psychological Bulletin* 63(6): 384-399.

Winnicott, D.W. (1971). *Playing and Reality.* London: Tavistock.