CHAPTER SIX: BALINT GROUP FACILITATION

Michael Balint, a psychiatrist working in London, in the 1950'2 and 1960's, established an approach to exploring the relationship between the patient and the doctor. This consists of case discussion in a small group setting of six to nine participants. The group is facilitated by at least one facilitator, often with the help of a co-facilitator. There are features considered to be especially specific for Balint groups. It can be helpful for the facilitator to bear these in mind when facilitating such a group, and make them explicit in the group.

SIX STEPS TO BALINT STYLE FACILITATION.

1. Maintain focus on the doctor: patient relationship and not problem solving

2. Stay with the presented case only

3. Encourage lateral thinking and imagination

4. Allow the presenter to 'sit back from the case' for a while

5. Ensure the presenting doctor is able to continue practice in a fit state on completion of the discussion

6. Speak up for the patient, if appropriate.

GUIDELINES FOR LEADING A BALINT GROUP

GENERIC SKILLS	SPECIFIC TO BALINT GROUPS
1.Confidentiality within group	1. Focus on doctor/patient relationship
2. Encourage "I" statements	2. Protect group members
3. Don't talk too much	3. Don't talk directly after your co-leader
4. Look at process rather than seek solutions	4. Discourage interrogation of the presenting doctor
5. Create a safe environment	5. Represent the patient
6. Arrange the chairs in a circle	*6. Space the leaders within the group
7. Enable all members to participate	7. Stick to the presented case, discourage anecdotes
8. Listen to and respect your co-leader	8. Encourage reflection and deflect questions appropriately
9. Accurate time keeping	

Facilitation of a Balint group combines generic group skills with a few extras, which are particular to Balint work. The list above may help to distinguish these.

* Co-facilitation
- Co-facilitators sit at opposite ends of the group so each can keep an eye on ½ the participants (point 6 above)
- Can be helpful to have specific tasks

1. The purpose of Balint group work is essentially for the exploration of the **doctor: patient relationship** in order to deepen understanding for the group members. In Balint work, problem solving is actively discouraged. This is a deliberate strategy designed to allow participants freedom to think expansively and creatively without searching for "right or wrong" answers. This supports a philosophy of subjective reality in the group, and creates a climate in which everyone is able to express personal opinions in safety, without fear of being judged 'right or wrong'. As such it is a potentially powerful strategy for learner-centred facilitation.

2. The case presented is often referred to as "a gift" for the group as all participants often benefit from exploring the case. By **sticking with the case** it is possible to honour the gift brought by the presenter, and not being side- tracked by a similar case which has come to the mind of another of the participants. It is a way of showing respect to the presenter who in turn knows their case will be given the full attention of the group for an agreed period of time.

3. Having created a climate in which things are neither "right or wrong" it is sometimes helpful to have participants **fantasise** about a case. From seemingly obscure and even bizarre fantasies some new insights may emerge about the case. Free association is one way of giving permission to participants to **think laterally** about a case. This can involve intuitive 'right brain' thinking, as mentioned in chapter two, and add an extra dimension to the learning environment and enjoyment within the group.

4. Once a case has been presented, a short period of time follows during which any factual matters can be clarified for the group, by the presenter. The facilitator then invites the presenter to **"sit back six inches"**. This requires the presenter to move their chair back six inches out of the circle of chairs. This signals to the group that the presenter is not available for discussion for a period of time, usually about 20 – 30 minutes. This avoids interrogation of the presenter on points of practice, and allows the group to consider the case dynamic for themselves. This also provides a 'safe harbour' for the presenter for a while, during which they can listen to comments and speculation about the case without feeling obliged to respond or justify something. This also gives the group an opportunity to pursue ideas without the presenter cutting them short with information such as "I thought of that and it didn't help!" This is potentially another very powerful strategy of learner-centred facilitation, for all concerned. On completion of the time allocated for the case discussion in the group, the presenter is invited 'back into the group' and their chair is moved back in by six inches. At this point the presenter is able to comment on the process, the points raised by the case, provide feedback to group members, clarify additional points or simply to leave the case as it is. In the spirit of learner-centredness the choice rests with the presenter.

5. Cases often have a significant emotional component for the presenting doctor, as well as for the group members. During discussion of the case it is possible that comments, speculations and even fantasies may have touched on a sensitive area for the presenter, unbeknown to the person making the comment. The facilitator has a **duty of care** to the presenter, similar to a doctors duty of care towards the patient, to ensure that on completion of a case discussion the doctor is fit to continue in practice. If something of emotional significance has arisen then it is the facilitator's responsibility to acknowledge this with the presenter and where appropriate make arrangements for care of the doctor. This is outside the scope of the Balint group, and this should be made explicit at the outset of the group work.

6. At times a group may agree that a patient's behaviour is undesirable or unacceptable and may then 'gang up' against the patient. This is when the facilitator has a role to **represent possible needs the patient** may have which the group have not yet considered. This may be done as an open question such as: " I wonder what someone in this position may feel?" or as a more focussed question like; "Is a need being met for the patient by this behaviour?". The purpose of this strategy is to offer further perspectives on a case which may not yet have been considered by the group. It also removes a potential judgement of the patient in terms of "right and wrong" or indeed "good and bad", further supporting the group ethos of a non judgemental climate.

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