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Editorial

Reflective practice in psychiatric training: Balint groups during COVID-19

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Abstract

Reflective practice is increasingly being recognized as an important component of doctors' professional development. Balint group practice is centered on the doctor–patient relationship: what it means, how it may be used to benefit patients, and why it commonly fails owing to a lack of understanding between doctor and patient. The COVID-19 pandemic led to unprecedented disruption to postgraduate medical training programs, including the mandatory Balint groups for psychiatric trainees. This editorial reports on the experience of online Balint groups in the North West of Ireland during the COVID-19 pandemic, and furthermore provides guidance for online Balint group practice into the future.

Keywords: Balint groups; online Balint groups; doctor–patient relationship; reflective practice

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Introduction

Balint groups have been developed in many countries and different medical settings since Michael Balint's original description of his work with general practitioners in the UK, all with the similar goal of raising the quality and therapeutic aspects of doctor–patient relationships (Johnson et al., 2004). Reflective practice is becoming more widely recognized as a valuable element for doctors' professional development (Mamede and Schmidt 2004). The use of case-based discussions is an example of reflective practice in psychiatric training (Omer and McCarthy 2010). College of Psychiatrists of Ireland (CPsychI) requires trainees to attend 40 sessions of Balint groups (a form of case-based discussions) for basic specialist training and 24 sessions for higher specialist training (CPsychI, 2019).

Michael Balint, a Hungarian psychoanalyst, was the inspiration for Balint groups. In 1948, Balint began working at the Tavistock Clinic in London. In 1950, he and his future wife Enid organized a series of seminars for general practitioners (Lakasing 2005). The focus of those seminars was on the doctor–patient relationship: what it meant, how it could be used helpfully, and why it so frequently broke down due to a lack of understanding between doctor and patient. In his book 'The Doctor, His Patient, and the Illness', Balint detailed his techniques. Several facets of the doctor–patient interaction were explored in the book, such as 'The drug doctor' '*the doctor herself/himself is the most frequently prescribed medication*' and 'The collusion of anonymity' '*patients may bounce between specialists with nobody taking responsibility for the patient as a person*' (Balint Michael, 1955).

Balint groups have grown into a global movement spearheaded by the International Balint Federation, which has 30 member countries, most of which are located in the Western Hemisphere (International Balint Federation 2021). According to Samuel (1987), the goals and objectives of Balint training are encouraging doctors to appreciate their interpersonal skills and learning to recognize their limitations, increase doctors' perception and understanding of their patients' communication, and help doctors to become aware of their blind spots in their interactions with patients.

Balint group structure

Balint groups are usually small with the number of participants ranging from six to 12. The group meets weekly or fortnightly, and each week a participant brings up a case for discussion by the group. The essential characteristics of a Balint group are summarized in Table 1. Effective leadership is the key to success of a Balint group. Traditionally, Balint groups were led by psychoanalysts, but it is now accepted that other professionals such as GPs and psychiatrists could be Balint leaders.

The International Balint Federation (2021) developed a set of guidelines for the accreditation of Balint group leaders. Johnson et al. (2004) identified the following essential characteristics of an effective Balint group leader based on their own research of 21 experienced Balint group leaders: (a) creates a climate of safety, acceptance, and trust, (b) establishes and maintains group norms, (c) promotes movement toward the group's task, (d) understands group process, and (e) the leader's personality/style.

Balint groups' effectiveness

Balint group research is diverse, scarce, and frequently methodologically flawed. However, evidence of the usefulness of Balint practice was found (Omer and McCarthy 2010; Van Roy et al., 2015). Methodological challenges, such as limited sample numbers and a lack of control groups, afflict studies on the effectiveness of Balint training. In the United States, family practice residents who

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Table 1. Essential characteristics of a Balint group (adopted with permission from the British Balint Society)

1. Small group of 6–12 participants
2. Defined group leader
3. Group members are in clinical contact with patients
4. The material of the group is based on the presentation of current cases giving the presenting clinician cause for thought
5. The discussion focuses on the relationship between the presenting doctor and his patient
6. Case notes should not be used
7. The group should not be used for personal therapy
8. Standard rules for small group working apply
9. The purpose of the group is to improve understanding of the patient's problems, not to find solutions

regularly attended Balint groups said it improved their engagement with challenging patients and helped them build empathic abilities. Some residents, however, avoided attending Balint groups on a regular basis due to the discomfort of presenting cases (Musham and Brock 1994).

The participants in a Balint group of GPs in Sweden study reported more positive perceptions about their profession and their relationships with patients than the control group (Kjeldmand et al., 2004). This is similar to the results found by Kjeldmand and Holmström (2008) in a qualitative study of nine GPs who had participated in Balint groups for three to 15 years; they identified the following interrelating themes: competence, professional identity, and a sense of security, which increased through parallel processes, creating a base of endurance and satisfaction, thus enabling them to rediscover the joy of being a physician.

Outcome studies of Balint groups in psychiatric training are limited. In a study of psychiatric trainees and counselors who took part in a Balint-style case discussion group in the UK (Das et al., 2003), the majority of the participants said they learned new skills such as developing 'an awareness of their own feelings toward patients and increased their ability to stay with, rather than withdraw from, difficult feelings'. Despite this, the groups were stressful, and several members struggled to adjust. To overcome this, Graham et al. (2009) recommend that group leaders take an active role in reducing anxiety by avoiding jargon, not permitting prolonged silences, and not interpreting group dynamics.

Several international publications have demonstrated that Balint groups are beneficial to medical students in terms of developing communication and empathy skills (Parker and Leggett 2014). In their recent randomized controlled study of 362 fourth-year medical students, Lemogne et al. (2020) found that Balint groups promote clinical empathy among medical students, in the short run. Similar findings were identified by Monk et al. (2018) in a systematic review; they concluded that Balint groups might help medical students to become more patient-centered, by increasing students' empathic abilities and supporting their personal and professional growth.

The effect of COVID-19 pandemic on postgraduate medical education

As the COVID-19 coronavirus spread, universities and training programs around the globe shifted to online learning in an effort to slow the spread of the disease. The pandemic also led to unprecedented disruption to postgraduate medical training programs. Traditional learning opportunities became scarce (Yuen and Xie 2020). Many outpatient clinics switched to phone clinics and phone triage. Trainers had increasing demands on their time as they adapted to different ways of working. Even within a department, social distancing limited the availability of face-to-face contact with trainers (Yuen and Xie 2020).

Given all of these sudden changes, the trainees experienced a dramatic drop in their in-person exposure to all aspects of their education, with no clear end point. The Royal College of Psychiatrists UK (2019) encouraged trainees to continue to reflect on these new experiences as well as connect with peers through virtual reflective groups where possible.

Table 2. Guidelines for online Balint group

1. Indications, timing, and duration are the same for online as for face-to-face Balint with Zoom invitation sent out with regular scheduling email.
2. A laptop or computer is preferable due to screen size for visibility and better engagement with all participants.
3. Participants encouraged to sign into Zoom 5–10 meetings ahead of the meeting
4. We recommend two group leaders (a leader and co-leader) as regular Balint. They can both host the meeting
5. The leaders highlight the confidentiality, confirming that the meeting will not be recorded and group rules
6. All participants leave their camera on with mic on mute when the 'Dr' is presenting. 'Dr' goes on mute when they 'sit back' to facilitate group discussion and re-joins when invited at the end
7. Otherwise Participants behave just as in a face to face Balint Group a) Sitting in a private confidential space. B) Remaining seated during the session. C) Ensuring good light. D)Keeping their background screen neutral (no distraction from inbuilt zoom backgrounds)
8. Participants encouraged to participate in discussion just as in face-to-face Balint with the option of the hands-up function to avoid talking over/interruption. This is monitored by co-lead
9. Debriefing: The leaders may choose to debrief online, once a meeting is completed. They may however choose to debrief at another time.

The North West of Ireland Experience on online Balint groups during COVID-19 pandemic

A Balint group for psychiatric trainees (10–12) in Sligo was started in 2009. The group leader (GMcC) has previous experience in Balint groups and is trained in cognitive analytic therapy. The group was co-led by educational tutor (SM) and a senior registrar (MZ). It is open to all psychiatric and GP trainees. We met every Wednesday morning for one hour and each week, one of the trainees presented a case for discussion by the group. The Balint groups continued online via the Zoom platform from April 2020 throughout the COVID-19 pandemic. Clear guidelines for online Balint were developed (Table 2).

The leaders of the group encouraged trainees to focus on the doctor–patient interaction and reflect on their emotional reactions rather than the actual management of cases. The group was held in a 'trusting' nonjudgmental environment. This new context allowed us to review the online Balint experience and compare it with the face-to-face Balint group experience. Participants' feedback was obtained informally and with an online survey.

All participants, 12 trainees and three facilitators were sent an anonymous electronic survey to retrospectively rate their online

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Balint experience (July–December 2021). The survey questionnaire (attached as Supplementary material) consisted of 18 items with quantitative and qualitative outcomes. Quantitative data were exported to Microsoft Excel for descriptive analysis. The last five questions in the survey included open-ended 'free text' responses, allowing qualitative analysis of the text (by MZ SM and GMcC) with consensus from the three researchers to identify key themes.

Informal feedback from the psychiatric trainees indicated that they enjoyed having the opportunity to reflect on 'difficult' cases. Another positive feedback was the ability to share information with other trainees and the feeling of solidarity it creates; one of the trainees described it as feeling 'everybody is in the same boat'.

Informal feedback was very positive from the GP trainees as well as their trainers. Their feedback was positive, both directly to the group and via their scheme organizer. They found it very useful to address the doctor-patient relationship from a different perspective. They (GP trainees) were very active participants from the start and continue to be involved. They also liked the fact that this group format had been developed in primary care.

Surveyed Trainees' feedback on the online experience was mixed positive and negative. The response rate was 80% for participants ($n = 12$). Of the respondents, 60% agreed / strongly agreed that online Balint help improving their morale, wellbeing, or job satisfaction and improving their confidence in raising concerns and issues relating to work. Fifty percent agreed / strongly agreed online Balint group helped work feel less stressful and provided a cathartic space and helped them to tolerate more difficult feelings such as uncertainty. Seventy-five percent agreed / strongly agreed that online Balint group renewed their interest and understanding of patients, especially those who may be perceived as 'difficult', help in becoming aware of their unconscious thoughts or feelings in relation to your patients and provided an opportunity to reflect on interpersonal aspects of work in a safe and supportive setting.

Most of the participants preferred face-to-face Balint, that it allowed more meaningful discussion and exploration of emotional aspects. They preferred online to no Balint and felt they got less out of the process of online with communication hampered. Facilitators additionally reported on difficulty accessing group dynamics.

One participant reported feeling positive about the online group, with no real difference in their engagement between physical and virtual meetings. Another trainee reported that they generally (including across other sites) find Balint to be a stressful rather than a stress relieving process. Trainees reported that they like the convenience of online as they could login from their cars or offices without worrying about finding a parking space in the hospital. Nonetheless, most of the trainees mentioned that they missed the social interaction meeting colleagues before after and during the session.

Overall our experience was similar to that of Das et al. (2003) in that new trainees in the group were initially hesitant to present cases, but as the group continued, their level of participation improved. Attendance improved as time went on, it was an adaptation to new ways of working and participants took longer to know and trust each other. Occasionally people blamed internet for not engaging. This can be addressed by effective leadership, clear ground rules, and preparation ahead of time.

Conclusion

Overall, both the trainees and the co-chairs found the availability of a Balint groups to be a rewarding experience. The number of trainees attending has increased over time, and they are all eager to discuss cases. The COVID-19 pandemic has had a significant impact on medical education. Preserving and maintaining high-quality teaching is essential not only to satisfy the College of Psychiatrists requirements but also to ensure that trainees develop the rich knowledge base, necessary to practice psychiatry. We must take immediate action and adapt novel techniques to ensure we maintain high-quality reflection and education in these trying times. This needs to be done while maintaining safety and wellness of the learners, educators, and patients.

Supplementary materials. To view Supplementary materials for this article, please visit https://doi.org/10.1017/ipm.2022.51

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