Role of a Balint group in hospice practice

Stelcer B.

University of Medical Sciences, Karol Marcinkowski Poznan, Faculty of Health Sciences, Poznan, Poland

ABSTRACT

Michael Balint was a Hungarian physician and psychoanalyst, and student of Sandor Ferencz, who applied in his medical practice elements of psychoanalysis.

Balint argued that the role of the doctor or therapist requires professional medical expertise alongside specific personality predispositions and skills related to the process of building good contact with the patient. An element of professional competence is the ability to recognize the emotional state of the patient and to view and control their own mental states and consciousness in their role in which affect the relationship with the patient.

One of the most effective tools for improving skills of emotional chords with the patient is to participate in group meetings conducted with the model formulated by Michael Balint. Balint groups aim is to develop the ability to effectively conduct patient and understand his own feelings as well as in the treatment process.

Hospice staff, has been struggling in his work with difficult and aggravating situations related to human suffering and fear of death. Participating in Balint groups allows them to achieve the wider look at the determinants of care of dying patients and their families and to counteract the phenomenon of the burnout syndrome.

Key words: Balint group, hospice

Corresponding author
University of Medical Sciences Karol Marcinkowski Poznan
Faculty of Health Sciences
Department of Clinical Psychology
70 Bukowska str., 60-812 Poznań, Poland
Tel. (61) 854 72 74, (61) 841 00 46
E-mail: stelcer@ump.edu.pl (Stelcer Bogusław)

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Michael Balint was born in Budapest in a family of Hungarian Jews. His father was a doctor of general medicine, and under his influence Michael graduated from medical school. Since 1919 he has worked with the Hungarian psychoanalyst Sandor Ferenczi, under whom he gets his own psychoanalysis. From the very beginning of his professional career Michael Balint skillfully combined such disciplines like: medicine and psychoanalysis. In his medical practice apply the elements of psychoanalysis, as an evidence of it, there is a paper from 1923 - "Psychoanalysis in the service of a medical practitioner." During this period, Michael Balint became interested in psychosomatic medicine. At the time of the Second World War, Balint trained social workers using his own method of training in group meetings emphasized its practical value in their activities. After the war, following the introduction health care reform in England in 1945, and the appointment public health service in November 1946 moved to London, Balint, encouraged by the positive reception organized by their group meetings for social workers, began in London in 1950, the implementation of a wider program of group meetings designed for primary care physicians (general practitioners). As a general medical doctor and psychoanalyst at the same time working for the Tavistock Clinic became more recognized specialist. Michael Balint was a founder of a promising idea aimed at shaping the personal characteristics of group participants, for the better functioning of the medical profession.

Medical profession requires a part of professional medical knowledge, personality predispositions and specific skills related to keeping proper interpersonal contact. Element of professional skills is the ability to recognize a patient's emotional state and to identify and control their own emotions and the way we shape the relationship with the patient. One of the most effective tools for improving skills of emotional chords with the patient is to participate in meetings groups so called Balint Groups.

The importance of Balint groups in the training skills to help the patient

Balint Groups do not have the nature of theoretical training. The subject of the analysis is real situations where real problems and issues are discussed. Participants do not expect the instructional procedure, as well as the therapeutic process. Its purpose is to present and understand the patient and the way he/she experience his/her illness. Looking at and exploring subjective emotional reactions, participants learn the skills that help them more appropriate treating a patient. Hearing about different situations and cases of disease, they are able to deepening medical knowledge. Improving competence is always based on reporting to the facts. Such method of working with physicians was aimed to reflect the relationship between healer doctor, therapist, and patient. Balint group participants become aware of problems in relationships with patients and acquire the ability to understand their dynamics.

Acquire skills such as: skills of listening to the patient and those who are involved in the healing process, to tolerate uncertainty, increase empathic skills, supporting the patient, observation of gestures and behaviors of the patient, the recognition of what is to accompany the patient in difficult moments for him, learning based on real cases of ignoring the theoretical digressions about the principles of building a contact, increased reflection, greater insight into the mechanisms of behavior and development and consolidation of the behavioral patterns of therapeutically beneficial for different types of patients.

This skill is accompanied by an ongoing opportunity to acquire relevant professional competencies, such as: ability to build proper relations with the patient, deepening of medical knowledge, learning and improvement of knowledge based on facts arising from medical practice and interpersonal skills and commu-nication.

Balint group consists of 8-12 physicians or other medical helpers, conducted by a qualified leader. Participants during approximately 1.5 hours are engaged in an analysis of the doctor patient relationship, the importance of which, they are trying to explain and understand. A participant presenting his history with the patient describes his encounter like he remember it. He does so without using notes or other records. On this basis, the other participants create a peculiar, subjective image and build an impression about the doctor, patient and their relationships. Participants after listening to this presentation shares their feelings, experiences and fantasies about to the presented relationship. Thanks to this a comprehensive picture of the doctor - patient relation is developed. The presenting case participant listens to it from a distance. Listening and recording the comments of participants the presenting case person, allow to reach insight into unknown aspects of his relationship with the patient. It helps to recognizes own style and way he conduct helping process and the impact on it to the patient.

Participating in Balint groups makes it possible to gain insight into unconscious of their own behavior, self-knowledge, or even limited transformation of personality features. The participant learns how to better focus on the patient

his experiences and perceptions of his personality in the perspective of his/her overall experience beyond the disease itself. This leads to the acquisition of the skills of effective therapy and contact with a sick serving well to the patient and his doctor. Persons participating in Balint groups realize that this form of training is an essential component of the teaching of physicians which wants to understand psychosomatic determinants of the illness.

Keeping Balint groups for taking care of the dying

Balint groups for a hospice staff are combined with a high probability of contact with the fear of suffering, dying and death. Achievement of a Balint's way of understanding of the doctor-patient relationship is to show many forms of psychological defenses used in order to find out acceptable distance between themselves and difficult emotional situation. Unconscious defense mechanisms are the results of personal and professional features. Working with dying patients poses a number of reasons for that distance position. Emotions are important in contact with a difficult patient, one who dies, in particular, [1]. There, in fact, are present with the greatest strength blocking emotional and unconscious power that creates distance from being exposed to the human suffering. Sackin and Salinsky drew our attention to this problem, suggesting that it is illusory to the belief in the possibility of uninterrupted duration of a state of being in the professional crust, which would supposedly protect against the experience of suffering [2]. These authors argue that it is impossible not to get personally involvement, and that it is impossible not to reach emotionally. Restraint of emotion, carries a high cost in a term of mental health. The authors emphasize that the role of the professional is included in the individual consciousness, remaining one of the aspects of identity.

The experience of intense emotions is personally living so somehow placed in work with patients who are dying. Leading the group for such a personnel need the leader to be aware that members probably experience many kinds of their own losses, and they are exposed to the emotional burden with the risk of burnout. Therefore, the problem of dealing with loss becomes a critical aspect of care for the dying. This is a phenomenon of particular importance, especially for the members of home care palliative care teams. The problem of a proper emotional distance and depth of involvement in the care of the dying man is a frequent theme in literature referred stories. Limits of liability for death of an another man in many ways runs through the stories chic were told among Balint groups.

The doctor, nurse, or psychologist, are working within a family system during the time of a special sensitivity. Theirs presence at home is even one of the factors affecting family dynamics. Many teams are working on and cares about their mission doing it that the attitude towards the patient and family is not only a formal by its character. This raises the risk of strong emotions in responding to the events occurring in the patient's home, and sometimes identification with a family member. It is not seldom that people are crying, express anger on the other team members when they are not as intensively involved. In working with dying patients and their families risk of identification, and idealism are particularly strong. In results of this mechanism is quite often than patients, and their families are embodied in the circle of friends. A common manifestation of this is to be engage in controlling behaviors of the family members, and connected them with a personal family and friendship system. All this in a unique light shows the problem of an adequate distance, which is responsible for establishing boundaries between caregivers and the patients and their families. Hence is the need not to provide conflicting and confusing signals, and an awareness of their responsibility for treatment and what I was communicating to the patient and the family [3]. This phenomenon is explained to the group work, where participants gain insight into what they are part of the family system with its complicated relations complex, or factor in the solution to these problems.

These problems are often raised at the seminars, where are discussed the phenomenon of emotional coping with the fear of dying and the accompanying pain. They are sometimes aggravating facts so heavily that it ran the risk of a burnout syndrome and the presence of one of the dimensions that is the emotional exhaustion. Do not overestimate is the need to make in the forum insight and understanding of the participants their own attitudes toward death and transience. The problem of proximity and limits of liability for the fate of the patient and the meaning of the term "right" to his case appears frequently in the contents of the analyzed cases. Phenomenon which directly binds to the above, to once again recall is the ability to find the right line between intimacy in the psychological sense of closeness and concerns expressed in the role of a professional. Emotions medical staff to patients dying although more and more frequently discussed in the literature does not improve the situation of healing, which often lack a vocabulary for this, to call the correct language is, how they react to dying and death, which are

phenomena to which one cannot remain indifferent.

Experience working in a convention of M. Balint confirm the presence of several significant problems arising in the process of communicating with the terminally ill.

According to Ann Faulkner these are as follows: breaking bad information, conspiracy of silence, denial of illness, difficult questions asked by patient and extreme emotional reactions of the patient [4].

The problem of communication is paramount. Nurses and doctors demands are made on how and quality of communication with patients and their families. Balint group reflected the emotional cost of taking the difficulties of care. Being sick, means to be dependent, hence the temptation in the person to feel hope to meet the expectations and desires to be filled by doctor [5].

Balint group work should give the participants a chance to see the flow of communication with the patient in a different light [6]. At some point the question should arise as to why the doctor acted in a certain way? Where there other options for dealing with the patient? It is not easy to change the style of communication, but the question of the existence of alternative options that appear when analyzing group, definitely raise awareness of the existence of other ways to communicate with patients. New spaces for the analysis and understanding of the relationships are presented in the group.

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