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Group Psychoanalysis: Reporting on 50 Years of Work

Teresa Gerace interviews Piera Ferrini about the professional Experience of Participation in Balint Groups

GERACE Good morning Dr. Ferrini, when in your medical career, coming from the internist area, did you feel the need to deepen areas pertaining to the emotional resonance of your work and did you think of approaching the Balint Groups and the training approach for caregivers, and with what motivation and expectation did you evaluate it?

FERRINI This question allows me to go back in my mind to the beginning of my career as a doctor when full of enthusiasm for my profession I was curious and open to new experiences. I graduated in Medicine and Surgery and qualified to practice my profession in 1982, I enrolled in the specialization in Internal Medicine and in 1987 I obtained my specialty. My work experience began as a substitute General Practitioner in Rome and as a doctor on duty at the USL of Grosseto in a village in the mountains. These were my first experiences of direct contact with patients and of responsibility in the management of clinical cases; I remember the difficulty of finding myself alone in making therapeutic decisions assailed by a thousand doubts. How different this experience was from the one I had in the hospital wards during my traineeship. As a substitute GP, I had to deal with situations that were sometimes difficult and complex from a clinical and relational point of view, gaining the trust of patients who had an in-depth acquaintance with the own doctor. On-call duty was equally demanding and a source of stress: I was alone with holiday and night shifts, I was called on the phone, and with the USL car I had to go to the patient's home often in another town or in the countryside. I still remember the phone ringing (blue phone, with buttons to press), if I heard it again today I would feel tachycardia as I did then. I treated trivial clinical cases at home, but also urgent cases (pulmonary oedema, renal/abdominal colic), practiced intravenous therapies/phleboclysis, waiting for the clinical improvement at the patient's home, and I do not hide the fact that I was also anxious.
These emotional and affective aspects of my profession were new and not easy to manage.

It was during this period (the years 83/85) that I became aware of a group training for doctors that was being conducted at the Pollaiolo by Dr Francesco Corrao on the relationship with patients and sharing the fatigue of carers, the Balint group.
The emotional impact with my helping profession and curiosity brought me closer to the Balint groups, I realized that I needed to listen in order to process emotions/frustrations and also satisfactions. I wanted to understand whether other colleagues also experienced the same difficulties as me on a daily basis and whether this emotional burden could also partly undermine their enthusiasm for the medical profession.

GERACE Can you describe to us the functioning and history of the Balint Groups?

FERRINI The history of the Balint Groups stems from research/intervention designed by Michael Balint and Enid Eicholz Balint. The research work was started in 1950 at the Tavistock Clinic in London and the first publication of the text "Doctor, patient and illness" where the "Balint method" is described is 1957. The book was first published in Italy in 1961.
Balint's interest in the doctor-patient relationship began in the 1930s in Budapest, in 1939 he moved to Great Britain and joined the Tavistock Clinic; there he met his future wife Enid who had already experimented with group clinical case discussion initiatives with social workers. In those years in the UK the National Health Service came into being, which completely removed General Practitioners from inpatient facilities, causing them to feel a loss of status, and entrusted them with the 'solitary' management of many patients, up to 4000; in this setting Balint decided to start a research/intervention with a group of General Practitioners. The setting was well-defined: weekly meetings led by M. Balint, the group's formative purpose, spontaneity in the participants' exposition of the clinical case; the focus of the group's discussion was to delve into the dynamics existing in the doctor-patient relationship and to understand the emotional components that come into play in this relationship in order to support the doctor in particularly complex treatment processes. The figure of the GP/MMG was considered fundamental by Balint as, unlike the specialist doctors consulted by the patients during the course of their illness, they knew their patients and their family histories.
In the Balint group the theme of the doctor-patient relationship is addressed and deepened by considering the patient as a person who brings a malaise and who has emotions and responses to the illness.
Regarding the functioning in the Balint groups in which I have participated, in general the group meets every 15 days for a duration of 1 1/2 hours, there are 2 conductors. The leader asks the group participants to bring a clinical case or work situation that has particularly affected or challenged them. The

colleague who presents the clinical case has about 15 minutes for the presentation, then there is a space dedicated to questions from the other participants to better contextualize the situation; in the next phase the person who has brought the case listens and does not intervene, while the other group members reflect on the case and seek explanations for the dynamics present in the care relationship; the conductors intervene to bring their own contribution or, if it happens, to bring the group participants back to a not too deep interpretative level. In the last quarter of an hour the participant who brought the clinical case comments and shares his or her impressions on what was elaborated by the group during the discussion. The leader can conclude the meeting with a concluding reflection on the clinical case. In my opinion the conducting of the group is fundamental for the development of a good harmony and collaborative climate in the group itself, the conductor must be able to assess the fine line between entering into a relationship (doctor/patient) that implies the involvement of deep aspects without affecting the participant's sensitivity.

GERACE Do you think, doctor, that in the Balint group training experience the doctor only brings his/her professional role into play or also his/her personal identity?

FERRINI I think that it is not possible to bring only one of the two aspects into play as it is also the personal identity of each of us that leads to play the medical role with certain characteristics. Doctors may find it difficult and frightening to approach this type of group training because not only the technical or scientific aspects of the clinical case presented are involved, but above all the relational and emotional aspects of the care relationship. This situation may intimidate the doctor, which is why it is very important that the group leader, maintaining the right balance between interpretation and reality, without a judgmental attitude leads the group participants to feel in a protected, respectful situation and to develop a climate of trust.

GERACE Do you think that sharing in a group setting, with other colleagues also from other specialities, and pooling feelings and emotional states can improve the maintenance of the operator's mind and use the group as a tool for facilitating thought?

FERRINI Theoretically yes, I am convinced that the sharing of work difficulties including the emotional ones involved in the job is very effective in a group setting. In practice, however, this training proposal receives very little support from doctors, and Balint groups are not very widespread in the institutional sphere. I believe that the malaise of health workers is very great and this makes it difficult to get in touch with one's own working suffering,

especially in the group setting. Another cause is the failure of the health institution to recognise the objective difficulties experienced by doctors; this increases frustration because it entails a lack of recognition of professional identity.

GERACE You know and esteem the Balint Groups, can you explain why? Does this trust have a specific origin in your experience?

FERRINI In my experience of participating in Balint groups, the presence of a dedicated, confidential and non-judgmental setting in which to talk and share particularly difficult work experiences helps to process stress and better understand the emotionality present in the relationship with patients. The professional relationship can be empathetic with some patients and can be difficult with others; the presence of a group that contains and accepts difficulties can be a support to move forward.
My first participation in a Balint group dates back to the late 1980s. The group was led by Dr Corrao and the meetings were held at the Center Group's Research "Il Pollaiolo" in Rome. At that time I was working both as a substitute general practitioner and as a doctor on call. The group met every 15 days (maybe once a month, I don't remember) and consisted only of doctors, including some psychiatrists. The formula immediately attracted me, to expose a case, particularly significant case, listening to the emotions/feelings that other colleagues brought seemed a great enrichment to me. Right from the start, the conductor's role seemed fundamental and incisive in the group's progress: Dr. Corrao had a great ability to analyze situations, he always managed to understand the emotions and difficulties present in that treatment relationship, making the clinical situation addressable and processable.

GERACE Doctor, you had the opportunity to know Dr Corrao personally, and this is a privilege because he was a master whom I only got to know through reading his texts and not personally. Would you suggest the Balint Group as a Medical Training activity? Can you give some examples?

FERRINI The Balint Group or a group as it is much discussed today that is an evolution of the classic Balint is certainly a useful and highly professionalizing tool. I think it would be a good idea to include it as early as the specialization course, bearing in mind that medical trainees, but also nurses in training, constitute (alas) a workforce to all intents and purposes, undergoing the same if not greater work stress than an experienced doctor. Young doctors in training have important responsibilities in the face of a lack of experience and in the presence of a tutor who often only has the function of supervising the work already done.

In my professional life I have participated in experiential groups organized as part of the institutional training offer; they were interesting meetings attended by doctors and nurses from the Emergency Department in which I worked. It was not easy to share and expose oneself by pooling the emotional components that are present in the work of care; it would be useful for the Director, the head nurse, to support the realization of these group meetings in the annual training scheduled, so that the professionals concerned would have the opportunity to participate.

GERACE In the institutional medical landscape, according to you, who have known and experienced it as a doctor yourself, is there a need for training that is not being listened to? Or is there a difficulty for doctors and medical institutions to conceive of themselves as needing training?

FERRINI I believe both aspects are present. There is little listening capacity on the part of the institution, and there is no interest in understanding where the workers' malaise comes from. The health institution puts the company budget first and there is only apparent interest on the part of the company management in understanding what the (management and) relational problems of the health workers are; on the other hand, corporate priorities are the containment of expenditure, which seems to be achievable only by cutting human resources and not by better utilization of them. Doctors are increasingly dissatisfied and frustrated, sometimes not feeling part of an institution whose purpose is to care for patients. All this increases rigidity and dissatisfaction and does not make it easier for them to listen to themselves and their needs.
The relational problems presented by Balint in the text "Doctor, patient and illness" are still present and for this reason the book is very topical; Balint also proposed a method for dealing with and improving these problems, yet to date this tool is little known and little appreciated in Italy. I wonder why, is it possible that it is just the aversion of doctors to get in touch with their own emotions and the difficulties presented in the treatment relationship? Perhaps an explanation is to be sought not only in the obtuseness of the institutions that do not propose Balint groups in their training plans to deal with relational problems, but also in the setting up and running of these experiential groups. I believe that the level of the group of healthcare professionals must proceed on a constructive set-up and must not travel by allowing Bionian assumptions to emerge and govern the group; this depends a great deal on the conductor who must be very clear in defining the framework of the group. Probably a conduction of doctors/health workers adequately trained in the conduction of GB could facilitate the emergence of emotions and difficulties in the group.

GERACE Do you think that the progress of science, information overload and the increasing importance of technology in the diagnostic and therapeutic pathway may contribute to the dehumanization of medicine? And how useful has the group been to you on this issue?

FERRINI I think this evolution is already taking place. Certainly the refinement and precision of diagnostic means have led to earlier diagnoses and greater possibilities for treatment. However, medicine is not an exact science, and although patients think that everything can be cured, this is not the case; certainly a good doctor-patient relationship improves the quality of care, increases adherence to treatment, and allows a human relationship and trust to be established with the patient that makes it possible to accept the disease and cure it. The doctor, however, often uses this improvement in diagnostic technology defensively. The group, by increasing the possibility of understanding complex clinical situations, can help to recognise the emotional resonance behind a defensive attitude.

GERACE Have you addressed the problem of user pressure on the public service and its limits in the groups you have been part of?

FERRINI I have participated in a number of Balint groups and especially in recent years problems have often arisen concerning the limited resources of the NHS and the user pressure that these limits pose. In the group discussion it emerged that the pressure from patients can be increased by the belief, unfortunately widespread in our society, that everything is curable, that it is possible not to grow old, and that death is only a distant eventuality that affects us little. Another aspect that emerged in the groups is the difficulty for the two actors (patients/users, health care personnel) to understand that some misunderstandings are related to the efficiency of a system that promises timing and quality of services that it is not always able to provide; this situation increases conflict and malaise. On the other hand, in the groups it often emerges that the fiduciary relationship between doctor and patient is being undermined, whereas constructive dialogue and a sharing of therapeutic choices are a trump card for treatment and adherence to therapies, overcoming the concept of the doctor's apostolic function.

GERACE And have you also found yourself sharing the experience of difficult, disturbing or uncooperative patients? And how did the group help you in an area that is often, in medicine, removed or contrasted with a medical action of rejection?

FERRINI Yes, it was an experience that I faced and that led me to a closed attitude towards the patient. In the group meetings I brought this experience

and the process of understanding that occurs through sharing one's work as a doctor in the group was very helpful to me in understanding my difficulties and recognising the reasons for my rejecting attitudes.

GERACE I conclude with a somewhat general question: do you think that the doctor-patient relationship can in some cases go beyond the illness and the treatment of symptoms? How has the group helped you in this respect?

FERRINI I am convinced that the doctor-patient relationship, although asymmetrical, involves an emotional involvement for both. We know that the illness often starts before the symptoms and that there is a period when the person is alone with his illness. When he turns to a doctor to find out what is going on, he enters into a relationship with the doctor and entrusts himself to him even if with mixed feelings concerning the possibility of dependence but also of failure of treatment. The doctor on the other hand cannot be indifferent to the patient's suffering, unless he raises barriers and takes refuge behind protocols and rules in order not to get in touch with the patient's suffering and his own relational difficulties. The group has always helped me to learn from experience as an emotional relationship with patients but also as a contact with my own emotionality.
I thank you for your generosity in sharing your experience and your work in this area that is so important for the improvement of the human relationship between doctor and patient, and I wish you good work.

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