Experiences and difficulties in the doctor-patient relationship and the possible role of Balint groups:

A qualitative study among general practitioners
Experiences and difficulties within the doctor-patient relationship and the possible role of Balint groups: 
A qualitative study among general practitioners

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# TABLE OF CONTENTS

## CHAPTER 1: GENERAL INTRODUCTION ................................................................. 1

The illness, the patient... and the doctor? ............................................................... 3  
  From a biomedical to a biopsychosocial perspective .................................... 3  
  Difficulties in the doctor-patient relationship .............................................. 4  
  What about research on the doctor-patient relationship? ......................... 6  
  What about the doctor? ...................................................................................... 7  

Michael Balint and Balint groups ........................................................................ 9  
  History ............................................................................................................. 9  
  What Balint groups are .................................................................................. 11  
     Setting ....................................................................................................... 11  
     Case presentations ................................................................................... 12  
  What Balint groups are not .......................................................................... 12  

Qualitative research and Lacanian theory ......................................................... 14

The present study: research questions and methodological approach ............ 16

References .......................................................................................................... 20

## CHAPTER 2: WHAT MAKES UP GOOD CONSULTATIONS? A QUALITATIVE STUDY OF GPS’ DISCOURSES ................................................................. 33

Background ........................................................................................................... 35

Methods ................................................................................................................ 36  
  Data collection and sampling ........................................................................ 36  
  Participants ...................................................................................................... 37  
  Analysis ............................................................................................................ 38

Results .................................................................................................................. 39  
  Biomedically-centered discourse .................................................................. 41  
     General description .................................................................................. 41  
     Themes ..................................................................................................... 41  
     Preferred problems .................................................................................. 42
<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Characteristics of Balint group participants</td>
<td>74</td>
</tr>
<tr>
<td>Themes – Process</td>
<td>74</td>
</tr>
<tr>
<td>Leadership</td>
<td>75</td>
</tr>
<tr>
<td>Evaluation of group – attendance</td>
<td>76</td>
</tr>
<tr>
<td>Historical-geographical articles</td>
<td>77</td>
</tr>
<tr>
<td>Reports – anecdotal articles</td>
<td>77</td>
</tr>
<tr>
<td>Reflective articles</td>
<td>77</td>
</tr>
<tr>
<td>Balint group observation as research data</td>
<td>78</td>
</tr>
<tr>
<td>Discussion and conclusion</td>
<td>78</td>
</tr>
<tr>
<td>Discussion</td>
<td>78</td>
</tr>
<tr>
<td>Limitations</td>
<td>80</td>
</tr>
<tr>
<td>Practical implications</td>
<td>80</td>
</tr>
<tr>
<td>References</td>
<td>82</td>
</tr>
</tbody>
</table>

CHAPTER 4: A LACANIAN VIEW ON BALINT GROUP MEETINGS: A QUALITATIVE ANALYSIS OF TWO CASE PRESENTATIONS 93

Background                                                                 | 95   |
| Lacan’s theory on imaginary and symbolic relating to the other         | 96   |
| Methods                                                                | 98   |
| Procedure                                                              | 98   |
| Participants and sample                                               | 98   |
| Data analysis                                                          | 99   |
| Results                                                                | 100  |
| Case 1 – ‘The dismissed shock absorber’                                | 100  |
| Case 2 – ‘The escaping approacher’                                     | 104  |
| Discussion                                                             | 107  |
| Conclusion                                                             | 110  |
| References                                                             | 111  |
CHAPTER 5: READING BALINT GROUP WORK THROUGH LACAN’S THEORY OF THE
FOUR DISCOURSES ........................................................................................................... 115

Introduction .......................................................................................................................... 117

Lacan’s theory of the four discourses ................................................................................. 118

Discourse of the master ....................................................................................................... 121

Discourse of the university ................................................................................................. 122

Discourse of the analyst ....................................................................................................... 123

Discourse of the hysteric ..................................................................................................... 124

Discourse interactions ......................................................................................................... 125

Methods ................................................................................................................................ 126

Data ....................................................................................................................................... 126

Data-analysis .......................................................................................................................... 126

Findings .................................................................................................................................. 127

Puzzlement: disjunctions in the discourses ......................................................................... 127

Hysterisation as the central aim in Balint group work .......................................................... 128

Discourse of the analyst: the motor of Balint group work .................................................. 130

Tackling impossibility: discourse interactions ..................................................................... 132

The end of the session: the potential transformation of the initial puzzlement ......... 135

Discussion ............................................................................................................................... 136

References ............................................................................................................................... 138

CHAPTER 6: GENERAL DISCUSSION AND CONCLUSION .................................................. 143

Summary of the main findings .............................................................................................. 145

Critical discussion .................................................................................................................. 147

From discourse-related difficulties to the puzzlement explored in Balint groups .. 147

Specificity of Balint groups ................................................................................................... 149

‘Balint discourse’ versus ‘medical discourse’ ....................................................................... 152

Limitations of Balint groups ................................................................................................. 153

Methodological reflections ..................................................................................................... 154

Qualitative research .............................................................................................................. 154

Terminological issues ............................................................................................................ 156
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The road to writing this dissertation took off long ago. Studying medicine, my colleague students and myself especially learned a lot about the amazing ways the human body functions and about the many things that can go wrong in this body. Further on our study road, we also learned about how to find out what possibly is going wrong in a particular body and what could be done about it. On rare occasions, a professor also focused on the owner of this malfunctioning body, i.e. the patient. However, we never heard about *how to be a doctor*, nor did anybody tell us that this might be not self-evident. This question formed the seed of the dissertation that I finish today.

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Kaat

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In this first chapter, we provide a general introduction to this dissertation by outlining the background ideas that resulted in our research questions. First, we discuss the raised importance that is attributed to the doctor-patient relationship over the last decades and briefly explore the literature related to ‘difficulties in the doctor-patient relationship’. We note that the literature on the doctor-patient relationship strongly focuses on the patient’s side; that there is a tendency to translate the doctor’s side in terms of skills to be acquired; and that a main focus is put on isolated factors and characteristics rather than on dynamic processes. Scarce studies indicate the important role doctors’ perceptions and attitudes with regard to several work-related aspects may play. Balint groups are put forward as a form of case discussion groups where the doctor-patient relationship can be explored. After a short exposition of what Balint groups are, we present the research questions that will be addressed in this dissertation.
THE ILLNESS, THE PATIENT... AND THE DOCTOR?

From a biomedical to a biopsychosocial perspective

Medical discourse has known a remarkable evolution, especially in the previous century. After decades of primacy of a predominantly biomedical model in medicine, a first shift towards more comprehensive and patient-focused care took place around the mid-20th century (Borrell-Carrió, Suchman & Epstein, 2004). This came down to a shift from a focus on “essentially objective procedures of diagnosing and curing organic pathology via appropriate therapeutic intervention” (Bower, Gask, May & Mead, 2001) in which “the patient’s illness is reduced to a set of signs and symptoms which are investigated and interpreted within a positivist biomedical framework” (Mead & Bower, 2000) to the incorporation of the patient’s perspective in medical practice. This evolution is closely linked to the introduction of the notion of ‘biopsychosocial medicine’ (Engel, 1977), in which disorders are seen as constituted of biological, psychological and social components. In the same spirit, ‘patient-centred medicine’ (Mead & Bower, 2000) gained considerable attention in the medical discourse. A focus on the exploration of patients’ psychosocial background, needs and expectations went hand in hand with a raised emphasis on aspects such as physicians’ communication skills, ‘shared decision making’ (e.g. Elwyn et al., 2012; Makoul & Clayman, 2006) and empathy.

This shift thus coincided with the recognition of the centrality of the doctor-patient relationship, which is all the more considered important in general practice or primary care (Bower et al., 2001; May, Dowrick & Richardson, 1996). It is regarded as the “medium through which the medical care is delivered” (Oprea, 2009). Moreover, general practitioners (GPs) themselves were increasingly confronted with the limitations of the biomedical model (Bower et al., 2001). One of the pioneers in recognizing the importance of the doctor-patient relationship was Michael Balint (1896-1970). He stated that “by far the most frequently used drug in general practice was the doctor himself” (Balint, 1964, p. 1). This is in line with the finding that in psychotherapy, the therapeutic or working alliance is a crucial curative factor (Drisko, 2004; Horvath, 2013; Martin, Garske & Davis, 2000). The raised importance attributed in research as well as in medical education to concepts such as biopsychosocial medicine (Engel, 1977, 1981), patient-centeredness (Mead & Bower, 2000) and relationship-
centered care (Beach & Inui, 2006) also bears witness of the weight attributed to good doctor-patient relationships. It is clear that however much a doctor exhibits excellent diagnostic and therapeutic skills, these skills may be unsuccessful if he or she fails to convince the patient of the treatment. Moreover, the clinical relationship between a doctor and a patient can have therapeutic or curing effects per se, just as this has been pointed out in psychotherapy. Kaptchuk et al. (2008), for instance, demonstrated the positive influence of quality contact with a clinician on patients’ symptoms (in this case diagnosed with irritable bowel syndrome).

**Difficulties in the doctor-patient relationship**

In the last decades, the doctor-patient relationship is more and more studied, although as a whole, this concerns only a very small research segment when compared to the amount of studies about ‘straightforward’ biomedical topics. Research on the doctor-patient relationship includes descriptions of different kinds of doctor-patient relationships (for an overview see for instance Oprea, 2009); its specific aspects (e.g. Horder & Moore, 1990; Huygen et al., 1992); the study of outcome effects of specific types of doctor-patient relationships (e.g. Franks et al., 2006; Mead & Bower, 2002); and the investigation of the difficulties related to this relationship. In the latter regard, several studies focused on “the difficult patient” (e.g. Corney et al., 1988; Haas, Leiser, Magill & Sanyer, 2005; Schafer & Nowlis, 1998; Sr-taeky, 1991; Steinmetz & Tabenkin, 2001), “the problem patient” (e.g. Drossman, 1978; Kaufman & Bernstein, 1957), the “hateful patient” (e.g. Groves, 1978; Levinsky, Friedman & Levine, 1999; Strous, Ulman & Kotler, 2006), or “the heartsink patient” (e.g. O’Dowd, 1988; Mathers, Jones & Hannay, 1995). Different factors were found to characterize these patients: more frequently, they tend to have mental or psychiatric disorders (Hahn et al., 1996; Jackson & Kroenke, 1999; Klein, Najman, Kohrman & Munro, 1982), specific personality traits (Elder, Ricer & Tobias, 2006; Haas et al., 2005; Hahn et. al., 1996; Schafer & Nowlis, 1998; Smith, 1995; Steinmetz & Tabenkin, 2001), more (severe) (Jackson & Kroenke, 1999) and/or specific medical problems (Elder et al., 2006) or problems for which no organic basis can be found (Schwenk, Marquez, Lefever, & Cohen, 1989). Moreover, these patients display poorer social and physical functional status, higher use of
health services and are less satisfied with care (Crutcher & Bass, 1980; Hahn et al., 1996; Jackson & Kroenke, 1999).

Other authors state that it is more correct to talk about “difficult doctor-patient relationships” or “demanding encounters” rather than “the difficult patient” (e.g. Nisselle, 2000; Sledge & Feinstein, 1997; Smith, 1995; Stacey, Henderson, MacArthur & Dohan, 2009). Among the reported difficulties in doctor-patient relationships, we find failure of communication between patient and physician (e.g. Anstett, 1980; Schwenk & Romano, 1992) as well as a mismatch of styles, norms, values, and expectations (e.g. Schwenk & Romano, 1992). Furthermore, contextual factors such as productivity pressure, fragmentation of visits (Haas et al., 2005) and factors related to the administrative system (Serour, Al Othman & Al Khalifah, 2009) were also found to contribute to difficult encounters.

Only few authors investigated the doctor’s part in these difficult relationships. Greater perceived workload, lower job satisfaction, lack of training in counselling and/or communication skills (Mathers et al., 1995; Serour et al. 2009; Haas et al., 2005), poorer psychosocial attitudes (Jackson & Kroenke, 1999; Hinchey & Jackson, 2011), low level of experience (Haas et al., 2005; Hinchey & Jackson, 2011), discomfort with uncertainty (Haas et al., 2005) and a failure to recognize the needs and expectations of patients (Anstett, 1980) were for instance related to doctors’ experiencing patients as difficult. Moreover, “difficult doctors”, i.e. physicians who report higher number of patients who are generally frustrating to deal with, tend to be younger, to work more hours per week, and to have more symptoms of depression, stress and anxiety (Krebs, Garrett & Konrad, 2006). These studies identified several doctor-related factors coinciding with the experience of difficult patients, but they instruct little about the way physicians perceive these difficulties.
What about research on the doctor-patient relationship?

In the previous paragraphs it became clear that the importance of the doctor-patient relationship has been recognized during the last decades. We also touched upon the difficulties related to this relationship that were described by various researchers. After scrutinizing this part of literature, three major remarks arose.

Firstly, research on these topics predominantly focuses on the patient, which is for instance reflected in the amount of literature focusing on ‘patient-centeredness’, ‘patient satisfaction’ and even on the ‘difficult patient’. As mentioned before, this increased focus on the patient’s perspective is to be apprehended as a reaction to the previous illness-focused, paternalistic model of medicine and definitely is laudable. The physician’s perspective, in contrast, is much less examined.

Secondly, the physician’s responsibility in the doctor-patient relationship is often translated into the acquisition of specific skills (empathy, communication skills, patient-centeredness,...). Although training and investigating these types of skills absolutely is an important matter, it is to be noted that they are highly prescriptive in nature (Gothill & Armstrong, 2008; May et al., 2004; Oprea, 2009): they are mainly presented as competences to be achieved. In this regard, it is often assumed that physicians are all similar in their ways of perceiving and learning things. The fact that this might be an incorrect assumption was for instance pointed out by Smith, Dorsey, Lyles and Frankel (1999), who found that attitudes are determinative in the acquisition of skills. Among such attitudes, they mentioned the need to be in control, the need to be pleasing, and several beliefs (such as ‘emotions are harmful and should be avoided’, ‘interrupting is rude’, ‘doctors should keep their distance from patients’,...). Furthermore, other authors pointed at the limitations of a mere focus on skills. For instance, Hall, Horgan, Stein and Roter (2002) underscored that research about the doctor-patient relationship often focuses on physicians’ and patients’ behaviour and skills rather than on motives and emotional states that may influence how physicians and patients behave. Again others oppose communication skills to notions such as authenticity (Salmon &

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1 However, in ancient Greece, the healing power of the doctor-patient relationship was already acknowledged (Cole, 2012). Hippocrates, for instance, noted that: “Some patients, though conscious that their condition is perilous, recover their health simply through their contentment with the goodness of the physician” (Hippocrates, Precepts VI). In the Greek perspective, the power of the doctor’s influence on the patient was recognized, but the notion of patient choice or patient autonomy was non-existent (Cole, 2012).
Young, 2009) or “mindful being-in-relation” (Zoppi & Epstein, 2002). Furthermore, from a psychoanalytic perspective, a mere focus on skills training or competencies that should be achieved ignores for instance the way doctors give meaning to and find satisfaction in their professional work.

Thirdly, the majority of research about difficulties in the doctor-patient relationship examine isolated factors, characteristics or behaviours (either related to the patient, the interaction, the context or the doctor), thereby disregarding dynamic connections and complex interactions between different aspects. More comprehensive and reflective approaches in which GPs’ perspectives are included are lacking. Such approaches, however, would do justice to the complexity of human experiences and the reactions they entail.

In sum, we can state that the importance of the doctor-patient relationship has been acknowledged – at least by some authors – and that a certain amount of research on this topic can be found. This research focuses more on the patient’s side than on the doctor’s, tends to emphasize skills and mainly describes difficulties in terms of factors and features, hereby overlooking the complexity of experiences and perspectives.

**What about the doctor?**

Medical practice is a challenging work environment as it is marked by uncertainty and complexity (Sweeney, 2006). Uncertainty related to medical practice includes for instance the limits of scientific evidence, the difficult application of generalized research results to individual patients, the often fuzzy boundary between what is ‘normal’ and what is not, the uncertain course of diseases, a lack of knowledge, ethical dilemmas,... (e.g. Beresford, 1991; Eddy, 1984; Fox, 1980; Ghosh, 2004; Politi & Légaré, 2010). One type of ‘answers’ to this uncertainty and complexity is the formulation of guidelines, that aim to steer medical decision-making. Guidelines can indeed be helpful to practitioners, although research also indicates many barriers with regard to evidence-based practice or the implementation of guidelines (Cabana et al., 1999; McKenna, Ashton & Keeney, 2003). Apart from guideline-related, patient-related and environmental-related barriers, we also came across physician-related obstacles such as lack of awareness, familiarity, agreement, self-efficacy or outcome expectancy (Cabana et al., 1999). Physicians are indeed not merely applicators of medical
guidelines or information processors, they are also human beings making sense of their interactions with patients, their professional role and their everyday practice (Sweeney, MacAuley, & Gray, 1998). It is noted that factors such as “emotions, bias, prejudice, risk-aversion, tolerance for uncertainty, and personal knowledge of the patient also influence clinical judgement” (Epstein, 1999, p. 834). Moreover, physicians’ “personalities, personal histories, family and cultural backgrounds, values, biases, attitudes, and emotional ‘hot buttons’ influence their reactions to patients” (Novack et al., 1997, p. 502). Not only do these factors influence clinical interaction, at the same time they shape it. This was powerfully translated into the idea that physicians use themselves as instruments in practicing medicine (Novack et al., 1997) or in the aforementioned idea about the “drug doctor”, i.e. the doctor him- or herself being the most frequently used ‘drug’ for the patient (Balint, 1955).

Scarce studies investigated GPs’ perceptions with regard to various topics. Some older studies (data assembled in 1987 and 1984 respectively) used questionnaires in order find a typology of GPs’ attitudes to general practice (Bucks, Williams, Whitfield, & Routh, 1990) or to correlate a medical versus a social orientation with doctor characteristics (Calnan, 1988). However, the use of questionnaires for exploring perceptions or attitudes implies some limitations, as the questions are based on the researchers’ assumptions, i.e. they measure only what they expect to be of importance (Hill, Chui & Baumann, 2013). Few other studies used qualitative data (interviews or written narratives) for investigating what GPs find effective in or meaningful about their work. For instance, Tomlin, Humphrey and Rogers (1999) briefly described what GPs perceive as effective health care, inferring three main types of definitions: clinical, patient related and resource related. Horowitz, Suchman, Branch and Frankel (2003) focused on brief written narratives of meaningful work related experiences, which resulted in the extraction of three themes: ‘changes in the doctor’s perspective’, ‘connection with patients in moments of intimacy’ and ‘making a differences in someone else’s life’. Finally, Fairhurst and May (2001, 2006) asked GPs what they found satisfying in their work and concluded that ‘good outcome’, ‘satisfying interpersonal relationships’ and ‘personal attributes that contributed to the doctor’s identity’ were paramount. In these studies, the GP’s perspective was investigated mostly through direct questioning, which means that they mainly concern perspectives the GP is aware of.
Despite the impact perceptions, attitudes, emotions, etc... possibly have, they often remain relatively unconscious to the practitioner (Epstein, 1999). The nature of these processes was very accurately phrased by Michael Balint calling them “highly subjective and personal, often hardly conscious, or even wholly beyond conscious control; also, as often as not, there exists no unequivocal way of describing them in words. Nevertheless, these events exist, and, moreover, they profoundly influence one’s attitude to life in general and still more so to falling and being ill, accepting medical help, etc.” (Balint, 1964, p. 302). Thus, if doctors are said to function as ‘instruments’ in medical practice or as ‘drugs’ applied to patients, they need to be respectively ‘calibrated’ (Novack et al., 1997) and ‘pharmacologically tested’ (Balint, 1955)\(^2\). With regard to these intentions, terms such as ‘personal awareness’ (e.g. Borrell-Carrió & Epstein, 2004; Novack et al., 1997; Smith et al., 1999; Smith, Dwamena & Fortin 2005), (self-)reflection (e.g. Clarke, James, & Kelly, 1999; Plack & Greenberg, 2005; Bethune & Brown, 2007, ‘reflexivity’ (Baarts, Tulinius, & Reventlow, 2000) or ‘mindful practice’ (Epstein, 1999) are sometimes found in literature. Although on a limited scale, several propositions with regard to these tasks are formulated and even taken up in the medical curriculum in some countries (mostly in the US). Novack et al. (1997) proposed several types of group discussions to promote physician personal awareness, such as ‘Balint groups’, ‘personal awareness groups’, or ‘interpersonal skills training programs’. Since Balint groups specifically focus on the doctor-patient relationship and do exist worldwide (including in Belgium), they especially attracted our attention.

**MICHAEL BALINT AND BALINT GROUPS**

**History**

Born as the son of a Hungarian general practitioner, Michael Balint (1896-1970) often accompanied his father during home visits and thus from a young age became interested in the doctor-patient relationship (Lakasing, 2005; Otten, 2002). Fascinated by a broad range of matters, Michael Balint studied medicine, completed a PhD in biochemistry and at the same time became a psychoanalyst (Swerdloff, 2002). Due to difficult work conditions in the

\(^2\) This is in line with the need for psychotherapists to “participate in reflective educational experiences” (Novack et al., 1997) or to engage in a personal therapy.
preamble of World War II, he moved with his wife and son to the UK in 1938. Shortly after, his wife suddenly died and after the world war, Balint moved to London, where he started working in the Tavistock Clinic. There he met Enid Eichholz (whom he later married) and together they started the first seminars for GPs in 1950 (Balint, 1969; Horder, 2001; Lakasing, 2005). These seminars were later called ‘Balint groups’. The first ‘Balint group’ (BG) consisted of GPs who had answered an ad in the Lancet in 1950, proposing a “discussion seminar on psychological problems related to medical practice” (Balint, 1969, p. 202). This is to be situated in a period where general medicine was under pressure and not well (Collings, 1950). Moreover, in the post-war period many patients suffered psychosomatic complaints, for which GPs were not trained. It was Michael Balint’s ambition to induce some psychoanalytical concepts (e.g. the unconscious, transference, ...) to the medical field (Ricaud, 2002) and “to study psychological implications in general practice” (Balint, 1964).

One of the first BG participants clearly described the aims and achievements as follows:

“It was not long before I realised that the central strand in these seminars was about the relationship between doctor and patient. Moreover, the focus was at least as much on the doctor as on the patient. We had to look at ourselves, and our habitual ways of thinking, feeling, and acting within the consultation, as well aspects of our patients which we had not hitherto thought significant. We learned to listen and observe less selectively.”

(Horder, 2001, p. 1039)

These initial seminars also had a research focus (they were called ‘training-cum-research’ groups (Balint, 1969)): they not only aimed to ‘train’ GPs, but also to investigate, as a group, aspects of general practice (Balint, 1969). In 1957, Michael Balint described the work in the seminars in his seminal book called ‘The doctor, his patient, and the illness’ (Balint, 1964).

Later, Balint groups began to spread around the world (Salinsky, 2002). From 1972 on, international Balint congresses were organized (http://www.balintinternational.com/congresses.html) and in 1975 the International Balint Federation was founded (Salinsky, 2002). However, despite the dissemination over several countries (with 19 adhering countries in 2002 (Salinsky, 2002) and 22 in 2014 (http://www.balintinternational.com/
membercountries.html)), Balint groups remain a minority activity (Salinsky, 2002)\(^3\).

**What Balint groups are**

**Setting**

*Meetings.* The initial Balint groups met on a weekly basis (Balint, 1979). Generally, meeting frequency is often either once per week, once every fortnight or once per month. Meetings generally last between one and two hours. Groups often subsist for several years.

*Participants.* Generally, the number of participants in a Balint group is between six and twelve. Although Balint groups were initially set up for GPs, some groups also welcome (or are exclusively organized for) other (para)medical professionals, such as nurses (Paal, 1978; Rabinowitz, Kushnir & Ribak, 1994, 1996; von Klitzing, 1999), specialists (Selvini, 1973), physiotherapists (Dahlgren, Almquist & Krook, 2000) and community health workers (Leggett, 2012). In order to encourage free speaking, participants generally are not supposed to cooperate professionally. In some countries, Balint groups are part of the medical curriculum, where medical residents or students are offered the opportunity or are sometimes obliged to take part in a Balint group for some time (Brock & Stock, 1990; Johnson, Brock, Hamadeh, & Stock, 2001).

*Leaders/facilitators.* Mostly, groups are led by one or two leaders, also referred to as ‘facilitators’ (Stein, 2003) or ‘animators’ (Kulenovic & Blazekovic-Milakovic, 1995). In some countries (including Belgium), formal leader-training programs and accreditation processes have been established (Salinsky, 2002). Often, group leaders are family physicians, psychologists, psychiatrists, or social workers (Brock & Stock, 1990; Merenstein & Chillag, 1999). Since Michael Balint had a psychoanalytical background, Balint groups were clearly psychoanalytically inspired. However, research and report articles point out that countries

\(^3\) In Belgium, Balint groups have been active since the 1970s. The second International Balint Conference took place in Brussels in 1974 and in the same year, the Belgian Balint Society was founded. During the initial years, there was a French-speaking and a Dutch-speaking wing in the Belgian Balint movement. At present, only the French speaking wing is active, with eight groups currently active (plus one additional group called ‘Post-Balint’, meant for experienced participants and animators). Two times a year, the Belgian Balint Society organises a symposium and publishes a journal called “Revue Balint”. For more information about the Belgian Balint Society, we refer to http://www.balint.be/
differ in the extent to which their groups are still led by psychoanalysts rather than physicians or psychologists without formal psychoanalytic training (Salinsky, 2002). Leaders’ tasks include creating a safe environment, encouraging exploration, avoiding premature solutions and tolerating silence and uncertainty (Johnson, Nease, Milberg, & Addison, 2004).

Case presentations

During BG meetings, one or more cases are presented and subsequently discussed (each case lasting about one hour). Cases always concern a difficulty a participant has experienced in his or her professional relationship with a patient; this concerns a patient they are currently treating (Balint, 1979), and that has given them “cause for thought, distress, surprise, difficulty, puzzlement or uncertainty” (Lustig, 2004). After one member has given a report about a patient, the other participants are asked to comment, to ask questions, and “to use their imagination, their knowledge and observation” (Balint, 1979, p. 470). Michael Balint (1969) stressed the voluntarily and spontaneous basis for the presentation of cases. This means that cases should not be prepared and that notes are not allowed. The rationale for this recommendation is explained as follows:

“The worker had to report freely about his or her experiences with the client, in a way reminiscent of ‘free association’, permitting all sorts of subjective distortions, omissions, second thoughts, subsequent interpolations, etc. I used this report (...) as something akin to the manifest dream text”.

(Balint, 1964, p. 300)

What Balint groups are not

In order to further explain what Balint groups are, we think it is useful to stress the difference with some other types of discussion groups for GPs or kinds of continuing medical education (CME).
Balint groups are not theoretical seminars, nor skills trainings: they are characterised by their non-didactic, participatory nature (Scheingold, 1988). Discussions consider actual situations and are by no means theoretical discussions about what good doctor-patient relationships should be like (Seidler, 1995). There is no teaching, no theory (Balint, 1969), nor is it a course in consultation-techniques (Kjeldmand, Holmström & Rosenqvist, 2004) or specific treatment modalities (Lustig, 2006). Remarkably, although some authors indicated the limited value of ex cathedra courses for affecting change in professional practice (e.g. Davis et al., 1999; Forsetlund et al., 2009), many CME courses still take this form⁴ (Pype et al., 2012). It was indeed already stated by Michael Balint (1964, p. 299) that “the only way to acquire a new skill is to expose oneself to the actual situation and to learn to recognize the problems in it and the methods of dealing with them. Being lectured to about problems and methods can help, but can never take the place of direct experience”.

Michael Balint (1967) very much stressed the fact that Balint groups are not therapeutic groups. He stated that in the groups only the participants’ ‘public transference’ is explored, never the ‘private transference’ and he underscored the importance of preserving the dignity, the independence and adult responsibility of each participant (Balint, 1967). In order to avoid the group becoming therapeutic, Balint advised leaders to restrain from making direct interpretations either on individual participants, or on group phenomena and to leave their ‘expertise’ aside (the only expertise they should have is on creating and maintaining a good working atmosphere in the group) (Balint, 1967). According to Balint (1964), leaders should just merge into the group as much as possible. For difficulties related to the private sphere, participants are recommended to search for therapeutic help outside the group.

Balint groups are no training in psychotherapy, although this might have been initially suggested by Michael Balint (1964). As mentioned before, general practice in postwar UK (where the first Balint groups were introduced) was confronted with many difficulties: these included for instance a high demand for mental health services and a shortage of mental health resources (Clarke & Coleman, 2002). This resulted in GPs having to deal with all kinds of patients for which they were not trained. We notice that some of these difficulties are still very up-to-date (e.g. long waiting lists in mental health care, limited psychological training in

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⁴ Pype et al. (2012) found that 80 % of postgraduate education in palliative care use lectures as a didactical technique.
medical education). Balint (1964) stated that at least one quarter to one third of the work of a general practitioners consists of ‘psychotherapy’. Without proper training, GPs are thrown back on their own resources, relying on ‘common-sense advice’ or reassurance. Although Balint acknowledged the potential usefulness of such strategies in general practice, he warned against the limitations and potential harmful effects of such ‘blind shots’ (Balint, 1964). Enid Balint (1969) stressed that the aim of Balint groups was never to teach the participants “to be minor psychotherapists” (p. 269); it is a matter of making doctors psychologically adequate in their role as GP (Jablonski, 2003).

Furthermore, Balint groups are not patient case discussion groups (Kulenovic & Blazekovic-Milakovic, 1995; Seidler, 1995). Balint groups are not about diagnostics, not even psychiatric ones. Neither the patient, nor the illness are at the centre of the discussions; the focus is on the doctor, the patient and the doctor-patient relationship (Horder, 2001).

Finally, Balint groups are not supervision groups; in any case the presenter remains fully responsible for the treatment of the patient (Balint, 1969). Neither are they team supervision groups, where the functionality of a group prevails over personal change or self-experience (Seidler, 1995). Moreover, it is generally even an explicit rule that participants work in different practices and do not professionally cooperate with each other (Speidel, 1983). This aims to promote openness to take a reflective and vulnerable position.

For further information and findings on Balint group research and writings, we refer to Chapter 3, where a review study on Balint groups is presented.

**QUALITATIVE RESEARCH AND LACANIAN THEORY**

As the main focus of our research is to explore the way GPs speak about (difficulties in) their everyday practice – both in interviews and in Balint group sessions –, a qualitative research methodology appeared to be most suited. Qualitative research very much focuses on the study of experiences from the participants’ perspective; it takes into account the complexity of these experiences, and allows for the discovery of unexpected results (Hill, 2006; Marecek, 2003). In this dissertation, three out of the four studies (Chapters 2, 4 and 5)
use a qualitative research methodology. The data used in these studies entirely consist of language or ‘verbal data’, i.e. interviews with GPs and Balint group discussions, each with their respective transcriptions. Moreover, for the analysis of our data we explicitly focus on language (e.g. phraseology, contradictions, social bonds that take shape through language, etc...).

Language was also a main interest and focus of psychoanalyst Jacques Lacan (1901-1981). His notions of ‘subject’ and ‘discourse’, both closely related to language, get an important role in this dissertation. Put briefly, the subject in Lacan’s theory is seen as an effect of the fact that human beings speak (Lacan, 1966). Early in life, experiences of unpleasure (e.g. hunger, pain,...) make the helpless infant cry, in this way making an appeal to the other (Verhaeghe, 2004). In most cases, this other, i.e. the care-taker, will react with acts and words; these interactions lay the foundations for the child’s subsequent intersubjective relationships and at the same time for the construction of an ‘identity’. However, the other’s response necessarily falls short since not everything can be put in words and since there is no definitive response to the dissatisfaction upon which the appeal is based. Put differently: the human being is confronted with a lack. In Lacan’s view, the experience of subjective lack is crucial to human beings and marks all later experiences in life. It is said that the subject is inherently conflicted or ‘divided’: one is not identical to oneself nor unambiguous. This becomes clear in Lacan’s distinction between subject and ego (Lacan, 1966). Where the ego is marked by images, by unity and a strive for understanding, the subject is characterized by incompletion, contradiction and complexity. The ego is involved with adhering meaning to language and thus with understanding. By contrast, the subject (also referred to as the ‘subject of the unconscious’) is fragmented and pops up to quickly fade away again. Therefore, narratives are not only considered to be a reflection of the way people try to make sense of what they live, they are also marked by specific phraseology, contradictions or things that remain unsaid. The latter seemingly nonsensical elements of speech are considered to be indicative of subjectivity. In order to elicit narratives in which the subject can pop up, encouraging people to speak freely is thus regarded as important with regard to our research aims. This is both what we aim at in the interviews we perform and what is promoted in Balint groups.

For a further introduction to Lacan’s concepts of ego and subject, we refer to Chapter 4.
Moreover, Lacan put forth different modes of dealing with subjective lack. In his theory of the four discourses, he outlines four ways for the ‘divided subject’ to deal with the human condition of lack, which results in different kinds of social bond, rooted in language. Two different, yet closely related angles guide the studies in Chapters 4 and 5. In Chapter 4, Lacan’s differentiation between imaginary and symbolic relating to the other, or put differently, between ego and subject, mainly frames the analysis. In Chapter 5, Lacan’s theory of the four discourses is used for interpreting Balint group meetings. This theory will guide us in ‘reading’ the difficulties GPs present in Balint groups as well as in understanding the way participants in Balint groups work with these difficulties. The relevant theoretical concepts will be further presented in the theoretical introductions of Chapters 4 and 5 respectively. The use of (aspects of) Lacan’s theory in a in the context of Balint group research context has – to our knowledge – never been used before.

THE PRESENT STUDY: RESEARCH QUESTIONS AND METHODOLOGICAL APPROACH

As demonstrated above, the doctor-patient relationship is considered important – all the more in primary care – and gained more and more attention in research and medical education. Important but nevertheless underexposed is the physician’s side of the story and more specifically physicians’ perspectives and constructs about interactions with patients and their everyday practice. Therefore, the way GPs make sense of their practice will be the focus in Chapter 2. This is translated in the following research questions: What types of discourses do GPs use in order to make sense of their everyday practice? What are the implications of the use of specific discourses? To this end, we conducted semi-structured interviews with 19 GPs, who were invited to talk about ‘good’ and ‘bad’ consultations. For the analysis, we interpreted these narratives in order to typify different discourses the participants used.

Next to this, we investigate the possible role of Balint groups as platforms where GPs’ ways of apprehending their everyday practice and more specifically their work with patients can be explored. In order to get an overview of the scientific literature on Balint groups, a review of Balint group research appeared to be indicated, as this was apparently lacking. This literature review makes up the study presented in Chapter 3. The main research questions
guiding this literature review questions were: What type of research topics are treated in research in Balint groups and what are the findings? ‘Web of Science’ and ‘Pubmed’ databases were searched and all English-language studies on BGs (empirical and non-empirical) were included. We basically discuss the methodology used, the main research topics and practical implications.

As it became apparent in the literature review that comprehensive studies on the way Balint groups work are lacking, we planned two studies (Chapters 4 and 5) investigating BG processes from a theoretical framework, i.e. Lacanian psychoanalysis. We aimed at gaining insight in the kind of difficulties participants bring to Balint groups, in the way these difficulties evolve during the group discussions and in the specific working mechanisms of Balint groups. Both studies rely on data gathered through non-participant observation of the monthly meetings of four Balint groups over a 15-month period (April 2011 – June 2012). Three of these Balint groups were located in Wallonia, the French-speaking region of Belgium, and one group was situated in the Netherlands. In total, 45 meetings (87 case discussions) were observed; from these, 33 meetings (68 case discussions) were audio-recorded. For each of the observed meetings, we noted down descriptions of the case presentations as well as reflections on the dynamics of the group discussion. In two groups all participants were GPs; the other two groups were mixed (including GPs, physiotherapists and nurses). More detailed data about the participating Balint groups can be found in Table 1.

In Chapter 4 we explore the way Balint groups function by means of an in-depth analysis of two BG case presentations and their subsequent group discussion. Staying close to the transcripts, we follow the evolution of the participants’ perspective on the initial difficulty. For the description of this evolution, we make use of Lacan’s differentiation between imaginary and symbolic relating to the other.

In Chapter 5, we perform a further exploration of Balint group processes by taking a conceptual approach. Starting with a close reading of five transcripts, we developed as a

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6 Due to the actual absence of Balint groups in Flanders, the Dutch speaking part of Belgium (which is where the authors originate from), we were compelled to analyse Balint groups elsewhere. The four participating Balint groups were those that were considered to be within a reasonable reaching distance (ranging between 60 and 160 kms) and that agreed to participate (i.e., four out of five groups).
research group a more abstract understanding of Balint groups work. Lacan’s theory of the four discourses frames this further conceptualisation of Balint group processes.

Finally, Chapter 6 presents a general discussion of the studies we performed. After a summary of the research results, we will discuss the main findings, indicate limitations and suggestions for future research.

The actual studies are presented in the following chapters. The studies presented in Chapter 2 and 3 were already published and are presented in their published form. The studies in Chapter 4 and 5 are both submitted for publication at two different A1-ranked journals. Given the fact that articles submitted to journals are supposed to be free-standing, some repetitions will be found over the following chapters. Moreover, given the word count restrictions proper to scientific journals, we were compelled to keep the text concise, which proved to be a difficult exercise at times.
Table 1. Descriptive statistics of the participating Balint groups

<table>
<thead>
<tr>
<th></th>
<th>Balint group 1</th>
<th>Balint group 2</th>
<th>Balint group 3</th>
<th>Balint group 4</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Number of participants</strong></td>
<td>8</td>
<td>8</td>
<td>9</td>
<td>10</td>
</tr>
<tr>
<td><strong>GPs/other</strong></td>
<td>8/0</td>
<td>5/3</td>
<td>5/4</td>
<td>10/0</td>
</tr>
<tr>
<td><strong>Female/male</strong></td>
<td>6/2</td>
<td>7/1</td>
<td>5/4</td>
<td>5/5</td>
</tr>
<tr>
<td><strong>Mean age (± SD)</strong></td>
<td>46 (±12)</td>
<td>44 (± 8)</td>
<td>52 (± 11)</td>
<td>47 (± 9)</td>
</tr>
<tr>
<td><strong>Mean years of participation current BG</strong></td>
<td>4,7 (range 2-10)</td>
<td>2,1 (range 1-5)</td>
<td>4,4 (range 1-6)</td>
<td>3,4 (range 1-8)</td>
</tr>
<tr>
<td><strong>Mean years of participation previous BGs</strong></td>
<td>0</td>
<td>0,25</td>
<td>3*</td>
<td>0,2</td>
</tr>
<tr>
<td><strong>Background leaders</strong></td>
<td>1 GP + 1 GP</td>
<td>1 GP + 1 psychologist</td>
<td>1 GP + 1 psychologist</td>
<td>1 GP + 1 psychiatrist</td>
</tr>
</tbody>
</table>

* Note: For this mean, data of two participants were not included: one was considered an outlier and for one participant no data on previous BG participation was available.
REFERENCES


Hill, C. E., Chui, H., & Baumann, E. (2013). Revisiting and reenvisioning the outcome problem in psychotherapy: an argument to include individualized and qualitative measurement. Psychotherapy, 50(1), 68-76. doi: 10.1037/a0030571


Horvath, A. O. (2013). You can't step into the same river twice, but you can stub your toes on the same rock: psychotherapy outcome from a 50-year perspective. Psychotherapy, 50(1), 25-32. doi: 10.1037/A0030899


What makes up good consultations? A qualitative study of GPs’ discourses

In this chapter, we explore GPs’ perspectives of their professional practice by listening to the way they speak about their work, and more specifically about ‘good’ and ‘bad’ consultations. To this end, we conducted semi-structured interviews with 19 GPs. By means of a qualitative analysis, we mapped patterns in the interview narratives and described the range of different discourses that could be discerned. Four discourses were identified: a biomedically-centered discourse, a communication-focused discourse, a problem-solving discourse and a satisfaction-oriented discourse. Each discourse was further specified in terms of predominant themes, problems the GPs prefer to deal with and inherent difficulties. Although most participants used elements from all four discourses, the majority of the GPs relied on an individual set of predominant themes. This study clearly indicates that there is no uniform way in which GPs perceive clinical practice. By focusing on the limitations of each discourse, this study can shed new light on some of the difficulties GPs encounter in their daily practice: being confronted with specific problems might be an effect of adhering to a specific discourse.

BACKGROUND

In medical literature, principles and guidelines that define ‘good medical practice’ or ‘good consultations’ are continually being developed. For instance, literature on evidence-based medicine (e.g. [1-4]), shared decision-making (e.g. [5-7]) and medical competencies (e.g. [8]) is vast in this respect. These principles and guidelines are corroborated by research findings that depict the way medical practice can best take shape, and aim to prescribe practitioners’ actions and attitudes. However, such a prescriptive approach is limited since it treats all individuals of a professional group, such as general practitioners (GPs), as similar in how they make sense of their clinical practice and neglects how individual GPs actually experience their everyday clinical work.

Previous studies indicate that in medical practice clinical decisions are not only based on scientific knowledge; interpretation and ‘tacit knowledge’ also play an important role [9,10]. Moreover, GPs differ in terms of their experience, capacity, personality and personal values [3,4,11,12]. To further explore this subjective component, qualitative approaches that view GPs as “reflexive, meaning-making and intentional actors” (2003: 49) [13] and that identify patterns in the way they think and speak about their daily practice may be useful [10]. In this paper we adopt such qualitative stance, and view GPs as sense-making agents that actively construct their professional realities [14].

Previous research investigating GPs’ perceptions of what they deem ‘effective health care’ [15] indicates that different criteria are used with respect to how clinical practice is evaluated. This might also apply to the way GPs evaluate consultations with patients, i.e., why certain doctor-patient interactions are deemed rewarding or difficult. Rather than merely outlining criteria that are explicitly mentioned by the participants, the present study intends to outline participants’ perspectives, by taking also into account what is implicitly referred to (e.g. by means of striking word choices or contradictions). By analyzing narratives from interview data, the authors map patterns in the way GPs speak about their daily practice. Following a bottom-up approach [16] that uses GPs’ descriptions and concrete examples of good and bad practice, this study examines a) the ideas and concepts used by GPs in relation to their work, b) the themes that spontaneously recur in the context of descriptions of their practice, and c) the difficulties highlighted as obstacles to good
practice. Focusing on these aspects, the discourses the participating GPs characteristically make use of are mapped out. Discourses are understood as reflecting the angle from which someone constructs reality [17]. Since language is considered crucial in the subjective sense-making process [13,18,19], this study focuses on the language that GPs use to construct narratives about their consultations. For reasons of clarity, the interview data from which the analysis started will be called ‘narratives’, whereas the results of the analysis will be denominated ‘discourses’.

**METHODS**

**Data collection and sampling**

The first author, a female researcher with a degree in medicine and psychology, conducted semi-structured interviews with 19 Belgian GPs between June 2011 and June 2012. All interviews were audio-recorded. GPs were recruited by means of snowball sampling [20]. Four GPs were contacted by telephone and invited for an interview on the broad topic of ‘consultations with patients.’ At the end of each interview, participants were asked to give the name of one or more colleagues that could be contacted for an interview. It was assumed that this method would facilitate a trustful atmosphere during the interviews. Only one GP declined participation due to time constraints. In order to obtain sufficient variation in the sample, demographic characteristics were taken into account when selecting new participants among the candidates named. All participants gave written and oral informed consent and completed a short questionnaire designed to gather demographic data and information about the GP’s practice.

In order to elicit GPs’ narratives on their practice, it was decided to opt for interview questions that were as open as possible, yet specific enough. Therefore, the semi-structured interview contained the following questions:

1. What do you consider to be a ‘good’ consultation? Describe this in general terms. What are the components of a good consultation according to you? Give one or more examples of a good consultation.
2. What do you consider to be a ‘bad’ consultation? Give examples of what you would consider to be a ‘less good’ or a ‘bad’ consultation.

In between successive interviews, the interview questions were repeatedly evaluated in terms of their appropriateness to provide the kind of data that was aimed at, i.e., rich narratives. Assessed as well suited, the interview questions remained the same during all interviews. In order to elicit rich narrative material special attention was paid to encouraging the participants to speak freely.

Following each interview, the interviewer made reflective notes regarding observations and impressions during the interview. Potential preconceptions due to the interviewer’s background were cut back by reflections and discussions among the researchers on the one hand, and by a constant focus on asking open questions during the interviews on the other hand. When the first nine interviews were complete, an initial stage of saturation was perceived by the authors. The interviews were transcribed verbatim and an in-depth analysis of the data was carried out. This analysis led to the identification of four characteristic discourses. Following this, ten more interviews were carried out with the aim of refining and validating the intermediate findings. Data collection was terminated when saturation was reached (n=19) [21]. This study was approved by the Ghent University Committee for Medical Ethics.

Participants

Nineteen GPs participated in this study. All participants lived and worked in Flanders, the Dutch-speaking region of Belgium, and had received their medical training at a university in this region. Of the participants, 11 were male and eight female; age ranged between 28–63 years (mean 42.42; SD 10.42). Their years of experience as a GP ranged from one to 39 years (mean 16.84; SD 11.27); seven participants worked in a solo practice, 12 in a group practice.
Analysis

The data were examined with a focus on the language used by participants during each interview. As stated above, the use of specific language is indicative of the broader discourse individuals employ in terms of making sense of (parts of) reality [11]. In line with Parker [22] and Foucault [23], the use of particular discourses can be thought of as “practices that systematically form the objects of which they speak” (1972: 49) [23]. Indeed, according to Crowe [18] “language constructs how we think about and experience ourselves and our relationships with others” (2005: 56). Moreover, specific jargon makes up patterns by means of which the meaning of practices and relationships is understood [19,24,25].

The method used in this study was guided by the analytical steps outlined by Parker [19,22], which is particularly well suited for finding discursive patterns in narrative data. Firstly, the interview transcripts were analyzed with the aim of identifying the type of language used by the participants in their responses. The language used by participants was then grouped into broader clusters of jargon words [19,20]. The interview transcripts were then re-examined to a) gather fragments that reflected the types of clinical problems GPs expressed preference for, and b) the difficulties they encounter in their practice. For the first nine interviews, 12 clusters of jargon words were discerned and grouped into corresponding themes. In the ten subsequent interviews only one additional theme was discerned (see Table 1). Following repeated discussions between the first two authors, 13 clusters of jargon words and their corresponding themes were then grouped into four discourses. The second author is a male university professor in clinical psychology, a psychoanalyst and has experience in doing qualitative research. A brief visual presentation of the analysis is provided in Figure 1.

![Data Flow Diagram](image)

**Figure 1.** Overview of the analytic process

- Jargon words clustered in 13 themes
- Preferences
- Difficulties

- 4 Discourses
Table 1. Themes arising during first and second phase of analysis

<table>
<thead>
<tr>
<th>First phase of analysis</th>
<th>Second phase of analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Decoding messages</td>
<td>Time management</td>
</tr>
<tr>
<td>Executing guidelines</td>
<td></td>
</tr>
<tr>
<td>Convincing patients</td>
<td></td>
</tr>
<tr>
<td>Advising patients</td>
<td></td>
</tr>
<tr>
<td>Pragmatic solution seeking</td>
<td></td>
</tr>
<tr>
<td>Medical expertise</td>
<td></td>
</tr>
<tr>
<td>Patients’ satisfaction</td>
<td></td>
</tr>
<tr>
<td>Referring patients</td>
<td></td>
</tr>
<tr>
<td>Economic thinking</td>
<td></td>
</tr>
<tr>
<td>Medically interesting cases</td>
<td></td>
</tr>
<tr>
<td>Positive rapport</td>
<td></td>
</tr>
<tr>
<td>Verbalizing intuitions/non-verbal behavior</td>
<td></td>
</tr>
</tbody>
</table>

Quality control was built into the analyses in the form of discussions between the first and second authors of this study during the whole process. Attention was paid to ensuring that the codes covered all relevant data [26]. Consultations between the first and second author focused on identifying which discourses could be discerned in the initial codes. The final results were verified by the third author, who is a female university professor, a psychologist, experienced in doing qualitative research and trainer in communication skills at the Faculty of Medicine. She particularly examined whether the discourses identified were supported by relevant interview fragments [20,26,27].

RESULTS

A detailed analysis of the GPs’ narratives resulted in the identification of four discourses: a biomedically-centered discourse, a communication-focused discourse, a problem-solving discourse and a satisfaction-oriented discourse, each specified in terms of
predominant themes, preferred problems and typical difficulties (see Table 2). These themes and discourses were identified across the interview data as a whole, and thus the description of the four discourses is not a typology of individual GPs. The discourses are illustrated by interview quotes (that were translated from Dutch to English).

Table 2. Overview of the four GP discourses on consultation identified

<table>
<thead>
<tr>
<th>Discourse</th>
<th>Themes</th>
<th>Preferred problems</th>
<th>Difficulties</th>
</tr>
</thead>
<tbody>
<tr>
<td>Biomedically-centered discourse</td>
<td>- Executing guidelines</td>
<td>- Medically ‘interesting’ problems</td>
<td>- Lack of knowledge or expertise</td>
</tr>
<tr>
<td></td>
<td>- Scientific interest</td>
<td>- Problems that can be framed biomedically</td>
<td>- Making bad impression to specialists</td>
</tr>
<tr>
<td></td>
<td>- Referring patients to specialists</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Medical expertise</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Communication-focused discourse</td>
<td>- Decoding messages and signs</td>
<td>- Problems with deeper psychosocial ground</td>
<td>- Not being able to decode messages</td>
</tr>
<tr>
<td></td>
<td>- Verbalizing thoughts and emotions</td>
<td></td>
<td>- Patient not open to communication</td>
</tr>
<tr>
<td>Problem-solving discourse</td>
<td>- Pragmatic solution seeking</td>
<td>- Clear-cut questions or problems for which the GP can provide a satisfying solution</td>
<td>- Stress of finding solutions for problems</td>
</tr>
<tr>
<td></td>
<td>- Advising patients</td>
<td></td>
<td>- Finding right balance in advising and convincing</td>
</tr>
<tr>
<td></td>
<td>- Convincing patients</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Time management</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Satisfaction-oriented discourse</td>
<td>- Satisfying your patients</td>
<td>- Nature of problem of minor importance; satisfaction and patient’s expectations rule</td>
<td>- Angry, dissatisfied, demanding or</td>
</tr>
<tr>
<td></td>
<td>- Economic thinking</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Positive rapport</td>
<td></td>
<td>- Patient’s lack of trust</td>
</tr>
</tbody>
</table>
Biomedically-centered discourse

General description

In this discourse, the language used by participants largely refers to science, medical knowledge, standards and guidelines, and the organization of medical care. A good GP is depicted as an expert in biomedical science, someone who has extensive technical expertise, knowledge of diseases and/or experience with the organization of the medical world. In this discourse, consultations are defined in terms of making and formulating diagnoses and prognoses, applying medical interventions, and taking up a mediating role in relation to specialist care.

Themes

GPs that made use of this discourse frequently referred to the application of medical standards and favored clear-cut problems that have clear-cut treatment guidelines. For instance, in describing a ‘good’ consultation, GP 2 referred to identifying a biomedical problem (high blood pressure) and his response (i.e., measuring the patient’s blood pressure a second time, making a follow-up appointment, reviewing the patient’s medication). Moreover, an attitude of scientific curiosity i.e., the potential discovery or revelation of a rare or unusual diagnosis, was regarded as inherent to a ‘good’ consultation, as illustrated by GP 5: “You also have scientific expectations (…), scientific curiosity: what will emerge from this?”

Some GPs associated ‘good practice’ with the correct referral of patients with serious medical problems to specialists. GP 5, for instance, repeatedly brought up the subject of making referrals, e.g., by describing a recent case of a seriously ill woman he had to refer to a specialist, his reaction to a patient’s demand for (an unnecessary) referral, and the importance of having a good relationship with specialists. “I think that being a GP (…) you should be able and dare to urge colleague-specialists [to see a patient], but in such a way that you do this seriously” (GP 5). By frequently commenting on the referral of patients, this GP underlined the inscription of his professional identity in a world of medical experts.
Preferred problems

Elements of ‘good’ consultations noted by some GPs included being exposed to medically ‘interesting’ problems and being acknowledged as an expert in biomedical matters. This was illustrated by GP 4 and GP 18, who referred to their prompt recognition of a (benign) medical condition that worried their patients. For example, in response to one patient who was anxious about an unusual rash, GP 4 stated: “And then I started to think, ‘I have an idea about what this is, it probably won’t be bad’ and then he showed me and I said ‘Yes! Look, it’s this, you don’t have worry at all, it appeared just like that and it will disappear in the same way’. And that’s so delightful....”

Difficulties

Missing a diagnosis or lacking medical knowledge (e.g. regarding dermatological problems (GP 5) or palliative pain management (GP 4)), technical experience (e.g. surgical (GP 5)), or orthopedic expertise (GP 4, 10) were frequently mentioned as examples of ‘bad consultations’. Other difficulties include making a bad impression on specialists, worrying about minor medical problems, or not being able to correctly assess a situation. Moreover, consultations without ‘interesting’ medical complaints were sometimes perceived as tedious by GPs who put a strong focus on medical conditions. In this respect, GP 3 reported experiencing difficulties giving examples of what he considered to be a ‘good consultation’. He stated that at the end of his working day he sometimes doesn’t actually remember the patients that visited him: “Like in any job, there are things that occur ten times per day and which you probably try to do well, but that’s more of a routine, I don’t suppose afterwards you think ‘great’” (GP 3).

Communication-focused discourse

General description

In this discourse, the focus is on the communicative elements of a consultation. ‘Decoding’ the patient’s message or ‘deciphering’ what the patient is consulting for is of major importance. In contrast to the biomedically-centered discourse, clinical signs and
symptoms are not considered exclusively in terms of biomedical diseases, but also seen as indicators of psychosocial distress to which the GP should attend. The consultation is perceived as a communicative context in which emotions and opinions should be ‘verbalized’ and attuned. In this discourse, a good GP is described as being able to ‘read between the lines’, or as having an eye for the psychosocial factors that might contribute to the patient’s problem. A good GP should have the skills to communicate his/her intuition and cope with his/her emotions during consultations. Conversely, consultations are described as difficult if the GP’s decoding and communicative effort proves to be in vain.

**Themes**

Some GPs explicitly referred to the decoding of patients’ messages, suggesting that one should often look for “the complaint behind the complaint” (GP 1) and listen to “what is not said as well [as what is]” (GP 4). The problem presented might not even be clear to the patient him/herself, as noted by GP 7: “What is most important is that the patient, when he leaves, got what he came for, consciously or unconsciously”. Decoding the patient’s message also includes taking into account non-verbal behavior, as noted by GP 7: “I think that a good consultation has to be..., where the patient can express, verbally or with his attitude, what he came for”. This is inherently linked to an interest in the broader contextual or psychosocial determination of the problem, as illustrated by GP 1: “When you visit an elderly woman, and if it was recently Mother’s Day and she didn’t see anyone [in her family], and the woman is not feeling well, you don’t have to make a big fuss about it or look further, you don’t need to administer tests to deduce that she could be depressed. Just look at the bigger picture”.

Other GPs emphasized that ‘good practice’ requires investment in communication. For some, verbalizing emotions or intuitions was mentioned as important. The patient’s verbal and non-verbal behavior is monitored closely and if a problem is perceived, this will be communicated. For example, GP 4 stated: “Sometimes I say, ‘I can see it, you’re not happy, it is as if you want something else. What do you want? What in fact do you want, or what did you expect?’” GP 14 referred to a moment when she had communicated non-verbal signs of disagreement between a man and his wife, stating [to the interviewer]: “You need to pay attention to the signals between people, and I think it was good that I had noticed
this”. Several GPs mentioned bringing something up for a second time with a patient if they felt something was not right. GP 1 remarked: “You immediately feel it in the relationship, like, ‘you’re worried about something or I am worried about something’, then you bring that up immediately. ‘I had the feeling that last time we did not really get there, or that I didn’t hear or understand what exactly it was about. I felt troubled’, then I try (...) to talk it through in order to be on the same wavelength again”. Similarly, all of the examples provided by GP 17 came down to the importance of mutual understanding: the need for an open stance with respect to the patient’s frame of reference and the verbalization of possible points of misunderstanding or conflict. By articulating her reluctance to give a certificate to a young patient who claimed to be unable to work, and instead helping the patient verbalize the real reason for the request, GP 17 was able to expose the underlying problem: a lack of knowledge about child-care organizations. “Why was this good? Well, because, in spite of a question that bores me (...), I tried to understand why she thinks she cannot work” (GP 17).

Preferred problems

Problems with a psychosocial basis are preferred. They are experienced as challenges that provide work satisfaction. For instance, with reference to the factors contributing to a patient’s somatic complaints (vague gastric complaints), GP 1 asserted: “Well, I think that when you offer a certain interpretation, people can get into an unguarded moment. These are delightful moments, because then they come closer to themselves. It’s nice for yourself as well, because you come closer to a possible solution, but that solution is not for me, they have to find it themselves”. In this discourse, interpersonal and psychosocial problems are experienced as both challenging and stimulating.

Difficulties

Difficulties can arise when the GP is unable to accurately decode the message or cues. For example, GP 1 stated: “It was a false feeling of a consultation being good”. This GP stated that, although he had a good rapport with his patient, it took 15 years for the patient to admit to having a severe alcohol problem (which explained many of her persisting complaints). Similarly, with reference to a patient who had lied about his drinking behavior and convinced him to fill out forms, GP 7 described it as: “Being duped (...) being deceived,
or not having seen through it”. Some GPs report patients’ ideas on communication or patients’ poor communicative capacities as posing difficulty at times. GP 1, for instance, stated: “But people have to be open to this. Some people are absolutely not into this. If I asked [a patient who consults with a sore throat]: ‘A sore throat? Is everything going ok lately? Are there problems at home or things like that…?’ [some will answer]: ‘I’ve got a sore throat.’ That happens”.

Problem-solving discourse

General description

In this discourse, the focus is on identifying problems and providing solutions. As derived from the Latin verb consulere and consultare, i.e., to apply to someone for advice or information [28], a ‘consultation’ can be defined as a situation where someone (i.e. a patient) presents with a problem and hopes to find a solution. The aim of the GP is to solve the problem pragmatically, making use of a broad range of tools. In this discourse, consultations are sometimes described as difficult if the patient’s problems and demands are vague, and if, in relation to these problems, the GP’s toolbox proves insufficient.

Themes

Some GPs referred to the idea of being pragmatic, aiming to ‘give’ the patient ‘something palpable’ at the end of the consultation. This might consist of a recommendation, a prescription, information, or an opinion about the development of a problem. This was illustrated by GP 2: “Generally, your patient will be satisfied if you can reach an objective, or if you make a concrete plan about how you will try to solve something. I think that’s most important to me” and GP 8: “A consultation, however good or pleasant it may be, is still a functional encounter, it has to yield something”. For GP 8, a consultation must be ‘functional’, in that there has to be a clear before and after; it must achieve a goal. GP 8 also acknowledged that this ‘functionality’ can be broadly interpreted. For instance, reassuring a patient’s wife, letting her voice her frustration about specialists and the changes in the couple’s life due to the diagnosed disease were considered equally as functional as setting up a treatment plan for her husband. Both GP 9 and 18 stressed the
importance of structuring consultations and demarcating problems. GP 9 stated: “Firstly, I think there needs to be some structure in the consultation, so that it’s not skipping from one subject to another”. Commenting on an example of a good consultation, GP 10 stated: “What I considered good in this consultation? I like to manage, I like to structure and organize things”. In this context, three GPs (GP 4, 14, and 18) highlighted the importance of a thorough ‘stock-taking’ of the patient’s questions at the beginning of a consultation.

In the context of structure and management, five GPs (GP 10, 11, 12, 15, and 16) highlighted the importance of ‘time management’. GP 15 and 16, for example, regarded (the feeling of) ‘having enough time’ as the first condition for a good consultation and GP 12 mentioned a ‘good flow’ as a crucial aspect of a good consultation. GP 11 highlighted the challenges associated with this ‘time management’ factor and evaluated one particular consultation as ‘good’ because he managed to complete it in good time, even though he had expected it to be difficult.

Some GPs stressed their advising-convincing role, which can range from responding to a patient’s request for advice to trying to convince the patient that he or she has a particular problem (e.g. smoking behavior), and subsequently providing advice. The type of advice that is given concerns medical matters as well as psychosocial matters (e.g. family problems, financial difficulties or emotional problems). GP 3 illustrated this when describing the content of his job: “Well, finally, just being a scientific advisor, [this is] the most simple [aspect], but indeed apart from that, also giving advice on certain family matters, divorces, deaths, advice on how to cope with emotions, how they [the patients] would literally be better off leaving someone, or not, whether some of their habits are good, and others not”.

**Preferred problems**

In this discourse, patients with clear-cut questions or problems are preferred. Patients with vague demands are often experienced as irritating, as illustrated by GP 3, when talking about a paranoid patient: “It’s a man who doesn’t put his cards on the table (...) he invents all kinds of stories. It’s almost impossible to figure him out, like, what exactly is he looking for?” This contrasts with the communication-focused discourse, where such patients are deemed challenging and interesting.
Difficulties

The urge to provide a ‘solution’ to the problems presented can be experienced as stressful by a GP. For example, GP 2 recalled a consultation where he had ‘promised’ a patient that his backache would be better in two weeks, which turned out not to be the case: “Maybe I created false expectations during that first consultation, ... but I always try to give something concrete at the end of a consultation, in that I say: ‘I expect this’ and, well, perhaps yesterday I got what was coming to me (laughing)”. Similarly, GP 12 reported the difficulty she experienced when she fruitlessly attempted to solve a couple’s communication problems surrounding the terminal character of the husband's cancer. In this situation, the position of mediator the GP found herself in seemed impossible to hold.

Several GPs mentioned having difficulty finding the right balance between advising and convincing patients. Too strong a focus on persuasion might induce resistance on the part of the patient. However, refraining from advising a patient is not deemed appropriate either. For example, GP 1 referred to the importance of expressing his personal opinion, especially in relation to complex medical matters. “Not actually deciding for the patient, but daring to offer an opinion, [which is] something I notice to be different with younger physicians, [who say to their patients]: you have the information, the choice is up to you”.

Satisfaction-oriented discourse

General description

In this discourse, the focus is on patient satisfaction and a smooth doctor-patient interaction. Some GPs repeatedly referred to the importance of the patient’s satisfaction, either for internal (such as the GP’s self-esteem) or external reasons (such as economic motives). In the latter case, the patient is understood as a client who consumes the GP’s services. Here, a good GP is defined as having pleased the patient, who will consult again the next time. Affective elements, such as a positive rapport and trust, also play an important role in this discourse.
Themes

Evidently, most GPs prefer their patients to be satisfied with the consultation, but some GPs’ functioning seems highly dependent on the patient’s satisfaction. This was illustrated by GP 2, who stated: “I am satisfied if I think or feel my patient is satisfied”. When asked to extract the elements that made him evaluate an example as good, GP 13 repeatedly stressed prioritizing the patient’s wishes, e.g., the patient’s wish not to speak about her depression or the patient’s wish to abstain from further medical intervention.

Pleasing the patient was occasionally motivated by economic factors. This was illustrated by some GPs’ concern for losing patients (i.e. patients consulting another GP). GP 5, for instance, stated that he would rather comply with a patient’s request for a referral than run the risk of the patient consulting another GP for a second opinion. This statement was immediately followed by the reflection that “in these times, we’re all competitors” (GP 5).

Some GPs referred to the importance of a positive rapport or connection with the patient during a consultation. GP 8 stated: “A good consultation means a good connection between two people. This means, both parties leaving with a content feeling. I do find this very important”. When reporting an example of a ‘good’ consultation, GP 7 outlined its main determinants, stating: “He [the patient] felt at ease, I felt at ease”. Similarly, GP 6 offered an example of a good consultation, stating: “It was a guy my age, [there was] a connection, in that we are both interested in sports, and this is nice if there is already a connection”. This emphasis on a positive atmosphere can stem from the GP’s personal needs, as illustrated by GP 8 who notes having experienced that, in the long term, “extra input into the affective part of a consultation” does not contribute to a better doctor-patient relationship or better medical outcomes: “The affective part, the mere affective part has diminished [over the years]. Perhaps because I need it less (...). So that extra [affective] input is not profitable. Not for me and not for the patient. Well, that’s only a satisfaction of needs, but it’s not effective, in no way”. This emphasis on positive affective elements of a consultation differs from what was described in the communication-focused discourse, in which communication in relation to a broad range of topics (positive and negative) is stressed.
Preferred problems

In contrast to the discourses outlined above, in this discourse the type of problem is less important than the match between the GP’s and the patient’s expectations.

Difficulties

Angry, dissatisfied, demanding or intimidating patients are experienced as difficult in this discourse. For GP 2, a ‘bad’ consultation was one in which the patient continued to ask for more information, even after he had responded to the patient’s questions for quite a while. A patient’s lack of trust in the GP is also mentioned as problematic. GP 4, for instance, reported experiencing extreme difficulty when a patient expresses distrust for the GP: “A bad consultation is when you feel, ‘oh there is no trust, they doubt you’”. Conversely, GP 19 emphasized the doctor’s need to trust the patient, referring to distrust on the physician’s side when a patient asks for certificates.

GPs’ preferences in the use of discourse

All four discourses identified in this study were, to a certain extent, used by the majority of the participating GPs. Reporting on their professional experiences, almost all GPs referred to one or more biomedically-centered themes, communication-focused themes, problem-solving themes and satisfaction-oriented themes. However, in most GPs’ narratives, the predominant presence of particular themes and discourses was observed (see Table 3).
Table 3. Preferred discourses and themes per participant

<table>
<thead>
<tr>
<th>GP</th>
<th>Themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP 1</td>
<td>decoding (D2), verbalizing (D2), advising-convincing (D3)</td>
</tr>
<tr>
<td>GP 2</td>
<td>guidelines (D1), pragmatic (D3), satisfying patients (D4)</td>
</tr>
<tr>
<td>GP 3</td>
<td>guidelines (D1), scientific interest (D1), advising-convincing (D3)</td>
</tr>
<tr>
<td>GP 4</td>
<td>medical expertise (D1), decoding (D2), verbalizing (D2), positive rapport (D4)</td>
</tr>
<tr>
<td>GP 5</td>
<td>guidelines (D1), scientific interest (D1), satisfying patients (D4), economic thinking (D4)</td>
</tr>
<tr>
<td>GP 6</td>
<td>guidelines (D1), medical expertise (D1), decoding (D2), positive rapport (D4)</td>
</tr>
<tr>
<td>GP 7</td>
<td>decoding (D2), time management (D3), positive rapport (D4)</td>
</tr>
<tr>
<td>GP 8</td>
<td>verbalizing (D2), pragmatic (D3), positive rapport (D4)</td>
</tr>
<tr>
<td>GP 9</td>
<td>pragmatic (D3), advising-convincing (D3)</td>
</tr>
<tr>
<td>GP 10</td>
<td>decoding (D2), pragmatic (D3), advising-convincing (D3), time management (D3)</td>
</tr>
<tr>
<td>GP 11</td>
<td>decoding (D2), pragmatic (D3), time management (D3)</td>
</tr>
<tr>
<td>GP 12</td>
<td>scientific interest (D1), pragmatic (D3), time management (D3), satisfying patients (D4)</td>
</tr>
<tr>
<td>GP 13</td>
<td>guidelines (D1), satisfying patients (D4)</td>
</tr>
<tr>
<td>GP 14</td>
<td>decoding (D2), verbalizing (D2), pragmatic (D3)</td>
</tr>
<tr>
<td>GP 15</td>
<td>decoding (D2), time management (D3)</td>
</tr>
<tr>
<td>GP 16</td>
<td>medical expertise (D1), decoding (D2), advising-convincing (D3), satisfying patients (D4)</td>
</tr>
<tr>
<td>GP 17</td>
<td>decoding (D2), pragmatic (D3)</td>
</tr>
<tr>
<td>GP 18</td>
<td>medical expertise (D1), pragmatic (D3)</td>
</tr>
<tr>
<td>GP 19</td>
<td>pragmatic (D3), advising-convincing (D3), positive rapport (D4)</td>
</tr>
</tbody>
</table>

*Note: D1 = discourse 1 = biomedically-centered discourse; D2 = discourse 2 = communication-focused discourse; D3 = discourse 3 = problem-solving discourse; D4 = discourse 4 = satisfaction-oriented discourse.*
DISCUSSION

This study examined GPs’ narratives about what they deem to be ‘good’ or ‘bad’ consultations in their clinical practice. The narratives were found to be patterned in terms of four discourses: a biomedically-centered discourse (with explicit reference to medical guidelines, scientific interest and/or referral to specialists), a communication-focused discourse (which focused on decoding messages and/or verbalizing thoughts and emotions), a problem-solving discourse (referring to the pragmatics of a consultation or on advising or convincing patients) and a satisfaction-oriented discourse (focusing on satisfying patients, either for internal or external reasons, and/or on creating a positive rapport with the patient). Each discourse identified was further specified in terms of preferred problems and inherent difficulties.

The four discourses appear to reflect distinct ways in which GPs approach their clinical practice, decipher the components of good and bad consultations, and qualify what they experience as rewarding or tedious in their practice. This study indicates that there is no uniform way in which GPs perceive clinical practice. Each of the participants appeared to be using a subtle mix of different criteria to define what they deem good and bad medical practice.

The themes and discourses identified appear to be related to distinct sources. On the one hand, the language used in particular discourses, such as the adherence to ‘medical standards’, ‘good communication skills’ or ‘patient satisfaction’, is clearly rooted in medical literature. Similarities with descriptions of medical competencies (such as Canmeds roles [29]) can also be noted. On the other hand, the present study demonstrates that GPs’ narratives are more complex and that personal criteria are also present in GPs’ descriptions of good and bad consultations. For example, some participants defined ‘good consultations’ as those in which the GP stands behind the proposed treatment, where the GP does not succumb to a patient’s demand if it conflicts with medical guidelines, or inversely, where the patient’s perceived wish is prioritized. ‘Good consultations’ were also described as those in which the GP’s professional identity in relation to medical specialists was established; where the consultation was well structured; where a complex situation was dealt with efficiently;
where a distinct before and after could be identified; or where there was a warm and trusting interaction between the physician and the patient.

In line with other authors who stated that GPs’ perceptions “control how they are doing their job” [30], we believe that the elaboration of different discourses might shed light on what drives GPs during their consultations and might help us gain further insight into clinical decision-making processes. Moreover, focusing on discourse can also shed new light on some of the difficulties GPs encounter in their daily practice. As this study demonstrated, each discourse contains certain limitations. For instance, experiencing the urge to provide solutions and thus repeatedly ‘promising’ to cure a patient reflected one of the limitations of the problem-solving discourse; granting a patient’s request to be referred to a specialist while deeming this medically unnecessary reflected one of the limitations of the satisfaction-oriented discourse; and experiencing consultations for ‘ordinary’ medical reasons as tedious reflected one of the limitations of the biomedically-centered discourse.

The link between a certain discourse and its inherent difficulties might be particularly relevant, as this study demonstrated that most participants used certain discourses more predominantly than others. Participants may thus be predominantly confronted with those difficulties associated with their preferred discourses. A detailed description of the diversity in GPs’ narratives on consultations might provide an alternative approach to exploring the difficulties associated with implementing good medical practice principles. While previous research has focused on the extraction of distinct factors that are correlated with these difficulties, such as limited awareness of guidelines, lack of time, poor quality of guidelines, patient preferences, and personal and professional experiences [31-34], a qualitative analysis of GPs’ discourses on consultations takes into account what Sweeney [4] identified as the ‘complexity in primary care’. Moreover, in this study, participants were asked for their perspective both in a direct way (description of criteria for good/bad consultations in general terms) and in a more indirect way (elaboration on concrete examples of good/bad consultations). By encouraging GPs to speak freely about concrete situations and analyzing the narratives given, this study aimed at gaining access to the reality that is constructed by the participants [17].
Presumably, the predominant use of specific discourses can in some cases be linked to external factors, such as work-related characteristics (e.g. work experience, practice characteristics) or accidental factors, (e.g. recent events, recent training). However, the data collected for this study do not permit an examination of possible correlations between discourses and external factors. Moreover, discourses are context specific [35]. In this study, only GPs working in the Flemish region of Belgium were recruited, which implies that all participants came from particular working conditions and medical training. Therefore, apart from being small, the sample used in this study was neither random nor representative (although attention was paid to obtain demographic variation in the sample). Concerning the methodology, the mere use of interview as data can be considered a limitation. Triangulation of the interview data with naturalistic data (e.g. written narrative material or actual doctor-patient interactions) could make the analysis more powerful. Moreover, further research on the implications of the variability in discourses used by GPs is needed.

Nevertheless, the outline of GPs’ discourses on clinical practice provided in this study can function as a framework to help GPs reflect on how they construct their own practice. This type of reflection is particularly relevant since variety in GPs’ discourses implies that a good match between doctor’s and patient’s perspectives is not self-evident. Rather than focusing on good doctor-patient fits, the GP’s ability to handle or to switch between different perspectives with regard to the same situation is considered useful. The framework that is presented in this study can also help GPs become more aware of their particular perception of medical practice, could help them manage the challenges met in daily practice and can enhance doctor-patient communication [36]. Participation in group discussions, such as Balint groups [37,38], where one is gently confronted with the limitations of the angle from which a situation is viewed, may also be helpful in this regard.
REFERENCES


29. RCPSC (The Royal College of Physicians and Surgeons of Canada) [http://www.royalcollege.ca/portal/page/portal/rc/canmeds].


As the scientific literature on Balint groups proves to be scattered, this chapter provides an overview of the literature on Balint groups published in scientific journals. To this end, ‘Web of Science’ and ‘Pubmed’ databases were searched and all English-language studies on BGs (empirical and non-empirical) were included in this review. Of the 94 articles included, 35 are empirical studies adopting a qualitative, quantitative or mixed methodology. The research topics that emerged include outcome, characteristics of BG participants, themes addressed in BG meetings, processes in Balint groups, leadership, group evaluation and attendance to the group. The remaining articles were classified as historical articles, reports and reflective articles, for which some of the main discussion themes are presented. Although research on Balint groups proved to be scarce and often methodologically weak, indications of the value of BG work were found. Points of interest that could to be further considered by BG workers and researchers were extracted (e.g. long-term BG participation, good leadership and ‘modified BGs’). Recommendations for future research on Balint groups are provided.

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1 This chapter is based on Van Roy, K., Vanheule, S., & Inslegers, R. (under review). Research on Balint groups: a literature review. Patient Education and Counseling.
INTRODUCTION

In the 1950s, psychoanalyst Michael Balint introduced seminars for general practitioners (GP) that were later called ‘Balint groups’ (BG) [1, 2]. These groups were set up in London and spread worldwide, though on a limited scale [3]. In BGs, GPs and/or other (para)medical professionals explore difficult interactions with patients through case presentations and discussions. Generally, groups comprise six to twelve members and one or two leaders and meet on a weekly to monthly basis over several years. In BG meetings, participants present cases that are subsequently commented on by the group, giving open expression of their thoughts, ideas and emotions. This way of functioning can help participants broaden their perspective on the initial difficulty they were having, and can thus influence their overall perception of their practice and interaction with patients [4-7].

Balint groups are sometimes said to be outdated. However, activities of Balint group societies (e.g. registration of BGs, organization of workshops and conferences) [8] and associated literature demonstrate that BGs are still very much alive. However, research on the functioning and outcome of BGs is relatively scarce and sporadic, and therefore not always easy to find. This might explain why the short introductory literature reviews in some articles mention incomplete and sometimes contradictory findings. Until now, no systematic review of the literature on BGs has been published. The purpose of this paper is to provide an overview of the literature on BGs that has been published in peer-reviewed journals. We discuss the characteristics of these studies and the implications for research and practice.

METHODS

Search strategy

Using ‘Balint group’ as a key word, ‘Web of Science’ and ‘Pubmed’ databases were searched until march 2014. No restriction was set for year of publication. Abstracts were reviewed and all articles treating BGs as a subject were included. All duplicates, non-English-language articles, meeting abstracts, book reviews, letters and editorials were excluded, as were articles that mentioned BGs only briefly in the context of another research topic.
References from each article were followed-up in search of further peer-reviewed studies. In order to get a general overview of the nature of publications on BGs, no further restrictions were imposed. All articles were imported into Endnote.

**Data analysis**

After reading through all included articles, a list of variables to be evaluated for each of the articles was composed. Three broad categories of variables were used: 1) general article information (year of publication, country of issue); 2) information provided about the BG (the author’s relationship to BGs, length and frequency of sessions, group composition, information on leaders, specifications on terminology used, and description/definition of BG); 3) type of paper, i.e. ‘empirical articles’ (using a quantitative, qualitative, or mixed quantitative-qualitative methodology), ‘historical-geographical articles’, ‘report-anecdotal articles’ (with or without case examples) and ‘reflective articles’. Articles using qualitative data were scored according to the NICE methodology checklist for qualitative studies [9]. These studies were rated independently by two researchers and disagreements were discussed. Articles failing to meet standards of quality for qualitative research were classified as ‘reports - anecdotal articles’. Given the purpose of this study (i.e. mapping out the range of articles on BGs), all quantitative articles were retained. However, their methods and results were critically appraised and potential remarks with regard to the interpretation of the results are provided below. Finally, for each article, the topic, topic variables and results or findings were summarized. As the overall body of literature was too diverse to make any meaningful quantitative synthesis, we chose to qualitatively synthesize the article topics and to present the results of the articles in a schematic way.

**RESULTS**

In Figure 1, the numbers of articles included and excluded throughout the search process are presented. The database search yielded 362 articles. Screening the abstracts led to the exclusion of 32 articles that were not related to BGs. After excluding duplicates (n = 60), non-English-language articles (n = 149), meeting abstracts, book reviews, letters and
editorials (n = 24), the number of included articles scaled down to 97. Hand searches and bibliographic review of the retrieved articles brought an additional 22 papers. Finally, 25 papers were excluded since they only marginally mentioned BGs. This resulted in a total of 94 articles included in this study.

Fig. 1. Flow of the literature through the review

**Article information**

*Articles excluded on basis of language.* Although only English-language articles were taken into account for this review, it is worth noting that a remarkable number of German-language articles (n = 116, comprising 78% of all non-English-language articles) were extracted from the original database search. Other non-English-language articles included
French (n = 15), Spanish (n = 8), Swedish (n = 4), Croatian, Dutch, Finnish, Hungarian, Italian, Slovene (all n = 1).

**Year published.** Although the total number of English-language papers on BGs is relatively low, a slight increase in the number of articles published over the years can be noted. Only four articles on BGs were found in the period prior to 1970. For each of the periods 1970-1979 and 1980-1989, 14 articles were found. This number raised to 21 for the period 1990-1999 and to 30 for the period 2000-2009.

**Country.** A large proportion of the papers included (60%) originate from three countries: the US (n = 29), the UK (n = 17) and Israel (n = 10). Other English-language papers originate from Germany, Australia, Croatia, South Africa, Sweden, Finland, Switzerland, Canada, Belgium, Italy, France, the Netherlands and New Zealand.

**Methodology**

From the 94 included articles, only 35 (= 37%) were empirical papers. Among these articles 21 used a quantitative methodology; 10 used a qualitative methodology; and 4 applied a mixed quantitative-qualitative methodology. Almost all quantitative studies made use of self-report questionnaires (relating to work satisfaction, burnout, attitudes, empathy, personality, psychosocial self-efficacy and evaluation) (see Table 1). For the qualitative studies, researchers mainly used semi-structured interviews, field notes, video-taped sessions, audio-taped sessions (with or without transcriptions) and open questionnaires (see Table 2).

The remaining articles (n = 59) were labeled ‘report - anecdotal article’, ‘reflective article’ and/or ‘historical article’. These included reports on BGs (e.g. descriptions of ‘modified Balint groups’, participants’ personal experiences), the presentation of one or more cases, discussions on aspects of BGs (e.g. group process, leadership issues), descriptions of the history of BGs (e.g. in a specific country or institute). As a number of these papers provided critical reflections, rich reports on personal experiences, or instructive information about the context of BGs that may be of interest for future research, they were included in this review.
The most common discussion topics from these articles are presented under the headings ‘Reports – anecdotal articles’ and ‘Reflective articles’.

**Balint group information**

Although BGs were initially set up for GPs, some papers address BGs for other professionals. These include BGs for nurses [10-13], “industrial physicians” [14], specialists [15], physiotherapists [16] and community health workers [17]. A relatively high number of papers report on BGs for medical residents [5, 18-27], medical fellows [28] or medical students [29-34]. Some BGs were mixed, including GPs, medical specialists and/or counselors, for instance [4, 35, 36]. Generally, BG participants do not cooperate with each other in their everyday work, yet some BGs are organized for professionals working in the same unit [13, 36-39]. Reports on other types of ‘modified Balint groups’ indicate the use of different proceedings, such as case preparation [19]; presenting cases in rotation [4, 40]; taking the most recent consultation as a case [17]; working on questions [10]; position related difficulties [14] and professional role conflict [28]; giving homework assignments [41]; combining meetings with theoretical teaching [4, 42]; rotating leadership [40] or modifying the BG according to a mindfulness technique [43]. Some modified BGs have different focuses (e.g. family systems approach [35]; cognitive therapy [41]; additional focus on diagnostics [36, 38]). Often these modified groups have different names such as ‘Balint-style group’, ‘Balint clinical reflection group’ or ‘Balint-like group’.

Generally, the number of participants in a BG is between 6 and 12, with extremes of 4 [34] to 15 [19, 24, 44] and 17 participants [45]. Meeting frequency is often once per week or once every fortnight, sometimes once per month. Meetings generally last between one and two hours, with groups lasting for one or two years. However, the period of group meetings is variable, ranging from approximately 6 to 12 weeks [4, 32, 34, 41, 46] up to 12 [36] and 17 years [47]. For the empirical articles, details on this type of information can be found in Tables 1 and 2. The shorter BGs are often student or resident groups, which in some cases are mandatory [4, 22, 48, 49] or mandatory during a first period [5, 21, 23]. Some authors stressed the need for longer participation in order to allow for change in the participants [11, 12, 50]. Mostly there are two leaders per group, with a medical and
psychological/psychoanalytical background respectively. In some cases there is only one group leader, but often no specification about the leader is provided. Moreover, often the author’s relationship to the BG (participant, leader or extern) is not mentioned.

**Article results – paper topics**

In this section, we briefly discuss the main findings of the empirical articles as well as the chief topics addressed in the other papers. Tables 1 and 2 provide some additional empirical article information, such as data and instruments used, number and profession of participants, assessment moments, data-analytic methods, estimated time of BG participation, topics treated and findings. Due to space limitations, only summaries of the findings are presented; for more information we refer to the articles themselves.

**Outcome – effects**

Several quantitative and qualitative studies reported on outcome or possible effects of BG participation. It should be noted that a number of quantitative papers claiming to report on ‘outcome’ were not categorized under this topic, as the design of those studies (i.e. lack of longitudinal measurements) did not allow for conclusions on outcome. Moreover, results on item level will not be discussed. For the quantitative papers, the following outcome variables of BG participation were addressed:

*Psychosocial self-efficacy* [11, 12, 18, 22, 27, 51]. All six articles addressing this topic made use of the Psychological Medicine Inventory (PMI). Three studies [11, 12, 27] found an increase in psychosocial self-efficacy while the other three [18, 22, 51] reported no significant increase. Interestingly, Rabinowitz [11, 12] reported significant changes only after long-term participation (i.e., 10 à 12 months) but not after short-term participation (i.e., 6 months).

*Burnout/satisfaction* [12, 19, 22, 43]. Two studies used the Maslach Burnout Inventory (MBI): one study [22] found no significant effect on burnout, while the other [19] did not allow for statistical conclusions. A third study [12] using two other burnout questionnaires
found a significant decrease in burnout levels after 10 months of participation, but not after 6 months. A fourth study [43] did not find any significant effect of BG participation on subjective satisfaction.

**Attitudes** [18, 22, 28, 41, 43, 52, 53]. Seven articles made use of different questionnaires and focused on different aspects concerning participants’ attitudes. Brock and Stock [52] presented leaders’ perceptions of attitudes or skills that are attainable through BG seminars; Dokter, Duivenvoorden and Verhage [53] reported individual changes in perception of patients; Adams et al. [18] found no significant effect of BG participation on professionalism; Ghetti et al. [22] found unchanged scores in participants’ empathy; Sekeres et al. [28] reported no significant rise in participant’s overall attitudes (only in domain "view of oneself as a physician") and Abeni et al. [43] reported a general maturation in participants’ defense mechanisms; finally, Hartmann’s pilot study [41] of participants’ attitudes towards somatising patients ’s remained inconclusive.

**Specific expertise/knowledge** [42, 45, 51]. Amiel et al. [45] found no effect of BG participation on breaking bad news; Rabin et al. [51] reported increased self-efficacy cognitions related to the treatment of drug addicts, although significant at last assessment only (= 30 months); finally, a third study [42] was inconclusive on the effect on knowledge of pharmacotherapy and psychotherapy.

It is remarkable that, apart from the effects on professionalism, breaking bad news and leaders’ perceptions of attitudes or skills attainable through BG seminars, all outcome measurements rely on self-report instruments. Next to quantitative measures of pre-defined outcome variables, some qualitative investigations of the effects of BG participation on participants were carried out. One pilot study [54] outlined the following criteria for defining the type of change BG participation might induce: ‘knowledge of one’s own limits’ and ‘minimal interference of one’s own psychopathology’. Four studies [4-6, 16] used semi-structured interviews to describe participants’ perception of the effect of BG participation. Among the effects were mentioned: understanding case dynamics, awareness of one’s own and patients’ feelings, using a new perspective or conceptual framework [4], competence in the physician-patient encounter, recognizing different aspects of professional identity [6], increased self-awareness and interacting with patients differently [5, 16]. Finally, Samuel
<table>
<thead>
<tr>
<th>Article</th>
<th>Instruments</th>
<th>Assessment moments</th>
<th>Participants (+ control)</th>
<th>Time in BG **</th>
<th>Topic + variables</th>
<th>Results (remarks)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abeni et al. 2013</td>
<td>REM-71 + SAT-P + GCQ</td>
<td>2 moments (start-end)</td>
<td>30 (8 caregivers + 10 physicians + 12 nurses)</td>
<td>30 hrs (1 hr - 30 sessions)</td>
<td>outcome: defense mechanisms, subjective satisfaction; process</td>
<td>maturation of defenses, no sign. effect on subjective satisfaction; process: group climate: ↑ engagement + ↓ conflict (only in group of caregivers)</td>
</tr>
<tr>
<td>Adams et al. 2006</td>
<td>PMI + Musick 360-degree evaluation (professionalism items)*</td>
<td>2 moments (start-end)</td>
<td>7 residents (+ 6 control)</td>
<td>21 hrs (1x/2wks - 1.5 hrs - 1 yr)</td>
<td>outcome: psychological medicine skills; professionalism</td>
<td>no sign. ↑ in psychosocial self-efficacy; no sign. ↑ in professionalism</td>
</tr>
<tr>
<td>Amiel et al. 2006</td>
<td>2 questionnaires evaluating OSCE (objective structured clinical examination)*</td>
<td>2 moments (start-end)</td>
<td>17 GPs (+ 17 control = BG participants)</td>
<td>18 hrs (1x/mnth - 1.5 hrs - 1 yr)</td>
<td>outcome: breaking bad news (BBN)</td>
<td>BG participation no effect on BBN</td>
</tr>
<tr>
<td>Bar-Sela et al. 2012</td>
<td>MBI + expectations questionnaire (topics + contribution)</td>
<td>2 moments (start-end)</td>
<td>15 residents (8 jr. - 7 sr. residents comparison)</td>
<td>78 hrs (1x/mnth - 1 hr - 1 yr)</td>
<td>outcome: burnout</td>
<td>effect of BG participation on burnout in conclusive (no significance tests)</td>
</tr>
<tr>
<td>Cataldo et al. 2005</td>
<td>JSPE + Work Satisfaction survey (3 items)</td>
<td>1 moment (retrospective)</td>
<td>74 GPs (+ 40 control = 6 mnth mandatory participation)</td>
<td>104 hrs (1x/wk - 1 hr - 2 yrs)</td>
<td>attendance/part characteristics: empathy; no sign. ↑ in empathy, no sign. ↑ in work satisfaction between ‘attendees’ and ‘non-attendees’</td>
<td></td>
</tr>
<tr>
<td>Dokter et al. 1986</td>
<td>questionnaire (own design); demographic - &quot;Balint characteristics&quot; - personality characteristics - Leary’s interaction rose</td>
<td>3 moments (start-18 mnths-end)</td>
<td>22 GPs (14 &amp; 8 GPs) (+ 22 control)</td>
<td>78 hrs (1x/2wks - 1.5 hrs - 2 yrs)</td>
<td>outcome: attitude + patient perception; part characteristics/attendance: attitude, personality, patient perception</td>
<td>complex results represented on individual level (e.g. perceiving patients differently) (no statistical tests)</td>
</tr>
<tr>
<td>Ghetti et al. 2009</td>
<td>MBI + PMI + JSPE</td>
<td>2 moments (start-end)</td>
<td>17 residents</td>
<td>12 hrs (1x/mnth - 1 hr - 1 yr)</td>
<td>outcome: burnout; psychological medicine skills; empathy</td>
<td>no sign. effect on burnout; no sign. effect on psychosocial self-efficacy; no effect on empathy</td>
</tr>
<tr>
<td>Hartmann 1989</td>
<td>attitude questionnaire (10 questions)</td>
<td>2 moments (start-end)</td>
<td>4 GPs (+ 4 control) - modified BG</td>
<td>19,5 hrs (1x/wk - 1.5 hrs - 13 sessions)</td>
<td>outcome</td>
<td>↓ experiencing somatizing patients time-consuming; ↑ use of cognitive therapy (results only on item level)</td>
</tr>
<tr>
<td>Johnson et al. 2003</td>
<td>MBTI + Rokeach score + WEPS + IE + FIRO-B + POI</td>
<td>1 moment (start residency over 18 years)</td>
<td>206 residents</td>
<td>104 hrs (26 hrs mandatory) (1x/week - 1 hr - 2 yrs (6 mnths mandatory))</td>
<td>attendance/part characteristics: personality</td>
<td>Proportion ‘non-attendees’ = 35 %; ‘non-attendees’ sign. less intuitive than ‘attendees’</td>
</tr>
<tr>
<td>Joukamaa et al. 1995</td>
<td>patients: SCL-25; GPs: assessment scale of patient’s mental health</td>
<td>1 moment</td>
<td>10 BG-GPs (+ 2 control)</td>
<td>?</td>
<td>part characteristics</td>
<td>BG participants: ↓ ability to detect patients’ mental disorders (control group n = 2)</td>
</tr>
<tr>
<td>Study</td>
<td>Design/duration</td>
<td>Participants</td>
<td>Process</td>
<td>Duration</td>
<td>Main Variables</td>
<td>Findings</td>
</tr>
<tr>
<td>-------------------------------</td>
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</tr>
<tr>
<td>Kjeldman et al. 2004</td>
<td>Questionnaire</td>
<td>20 GPs (5 BG &lt; 1.5 yrs; 12 BG &gt; 1.5 yrs) (+ 21 control)</td>
<td>Part from different groups</td>
<td>6 à 8 hrs (1x/week - 1 hr - 6 à 8 wks)</td>
<td>Evaluation BG</td>
<td>Experienced BG participants: overall significant higher scores (except for ‘workload’).</td>
</tr>
<tr>
<td>Parker &amp; Leggett 2012</td>
<td>Evaluation</td>
<td>20 students</td>
<td>Post every session + post participation</td>
<td>6 à 8 hrs (1x/week - 1 hr - 6 à 8 wks)</td>
<td>Evaluation BG</td>
<td>Sessions rated positive; contribution of BG participation to educational needs rated medium (only descriptive statistics).</td>
</tr>
<tr>
<td>Rabin et al. 1996</td>
<td>PMI + questionnaire</td>
<td>22 doctors</td>
<td>4 moments (start-6 months - 18 months-end)</td>
<td>144 hrs (1x/2 weeks - 2 hrs - 2.5 yrs)</td>
<td>Outcome: Psychological medicine skills; Drug-treatment self-efficacy</td>
<td>No significant ↑ in psychosocial self-efficacy; Significant ↑ in self-efficacy cognitions related to the treatment of drug addicts.</td>
</tr>
<tr>
<td>Rabinowitz et al. 1994</td>
<td>PMI + participants listing important mental health topics</td>
<td>13 nurses</td>
<td>3 moments (start-midden-end)</td>
<td>48 hrs (1x/2 weeks - 2 hrs - 1 yr)</td>
<td>Outcome: Psychological medicine skills</td>
<td>Significant ↑ in psychosocial self-efficacy (long-term but not short-term); No significant ↑ in number of psychosocial repertoire topics.</td>
</tr>
<tr>
<td>Rabinowitz et al. 1996</td>
<td>PMI + burnout questionnaire (Shirom + Melamed)</td>
<td>10 nurses</td>
<td>3 moments (start-midden-end)</td>
<td>40 hrs (1x/2 weeks - 2 hrs - 10 months)</td>
<td>Outcome: Psychological medicine skills; Burnout</td>
<td>Significant ↑ in psychosocial self-efficacy; Significant ↓ in burnout (long-term but not short-term).</td>
</tr>
<tr>
<td>Sekeres et al. 2003</td>
<td>Attitudes + Evaluation questionnaire</td>
<td>27 residents (modified crossover study)</td>
<td>3 moments (start - 6 months - 12 months (follow up))</td>
<td>18 hrs (1x/2 weeks - 1,5 à 2 hrs - 6 months (≈ 10 sessions))</td>
<td>Outcome: Attitudes; Evaluation BG</td>
<td>No significant ↑ in attitudes (only in domain “view of oneself as a physician”); Evaluation: Safe group, decompress, social activity.</td>
</tr>
<tr>
<td>Stojanovic et al. 2004</td>
<td>Questionnaire on knowledge about pharmacotherapy (5 items) and psychotherapy (3 items)</td>
<td>111 BGs-GPs &amp; specialists in primary care - Modified BG</td>
<td>2 moments (start-end)</td>
<td>? (4 weekends)</td>
<td>Outcome</td>
<td>Results mainly comparing GPs &amp; specialists in primary care.</td>
</tr>
<tr>
<td>Turner &amp; Malm 2004</td>
<td>PMI</td>
<td>6 residents (+ 8 control)</td>
<td>2 moments (start-end)</td>
<td>18 hrs (1x/2 weeks - 1 hr - 9 months)</td>
<td>Outcome: Psychological medicine skills</td>
<td>Significant ↑ in psychosocial self-efficacy.</td>
</tr>
<tr>
<td>von Klitzing 1999</td>
<td>Session transcriptions (word counts)</td>
<td>7 nurses</td>
<td>1 moment</td>
<td>? (≈ 1.5 hrs - 1 yr)</td>
<td>Process BG: Verbal + reflective activity</td>
<td>Preference to discuss terminally ill, female patients of same age; Significant ↑ verbal activity participants; Significant ↑ reflection on patient; Significant ↓ reflection on self.</td>
</tr>
</tbody>
</table>

**Quantitative parts in mixed method papers**

<table>
<thead>
<tr>
<th>Study</th>
<th>Design/duration</th>
<th>Participants</th>
<th>Main Variables</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Musham &amp; Brock 1994</td>
<td>MBTI</td>
<td>16 residents (9 frequent attenders vs 7 infrequent attenders)</td>
<td>Attendance (frequent vs infrequent attenders); Part characteristics: Personality</td>
<td>Tendency frequent attenders more intuitive than infrequent attenders (no significance tests).</td>
</tr>
<tr>
<td>Parker &amp; Leggett 2014</td>
<td>Evaluation</td>
<td>42 students</td>
<td>6 à 8 hrs (1x - 1 hr - 6 à 8 wks)</td>
<td>Evaluation BG</td>
</tr>
<tr>
<td>Article</td>
<td>Instruments</td>
<td>Assessment moments</td>
<td>Participants (+ control)</td>
<td>Time in BG **</td>
</tr>
<tr>
<td>--------------------</td>
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<td>--------------------</td>
<td>--------------------------</td>
<td>---------------</td>
</tr>
<tr>
<td>Brock &amp; Stock</td>
<td>questionnaire (own design)</td>
<td>n/a</td>
<td>354 family practice residency directors</td>
<td>n/a</td>
</tr>
<tr>
<td>1990</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Johnson et al.</td>
<td>questionnaire (cfr Brock 1990)</td>
<td>n/a</td>
<td>298 family practice residency directors</td>
<td>n/a</td>
</tr>
<tr>
<td>2001</td>
<td></td>
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<td></td>
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</tr>
</tbody>
</table>

Legend

**Abbreviations instruments**
- REM-71: Response Evaluation Measures-71; SAT-P: Satisfaction Profile; GCQ: Group Climate Questionnaire – short version; OSCE: objective structured clinical examination; MBI: Maslach Burnout Inventory; PMI: Psychological Medicine Inventory; JSPE: Jefferson Scale of Physician Empathy; MBTI: Myers-Briggs Inventory; Rokeach score; WEPS: Work Environmental Preference Schedule; IE: Rotter’s Internal-External Locus of Control; FIRO-B: Schutz’s Fundamental Interpersonal Relationship Orientation Behavior Test; POI: Personal Orientation Inventory
- *: if instrument is not self-report
- **: Time in BG: approximate number of hours calculated by multiplying mentioned session frequency (x/week or x/month), session length (hours) and overall duration of Balint group (weeks, months or years) (possible holiday breaks could not be taken into account, thus for the longer lasting groups the calculated numbers may be slightly overestimated).
<table>
<thead>
<tr>
<th>Article</th>
<th>Data + participants</th>
<th>Analysis</th>
<th>Time in BG**</th>
<th>Topics</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brock &amp; Johnson 1999</td>
<td>process notes of 66 BG sessions with GPs</td>
<td>description</td>
<td>? (1x/wk - ? - ?)</td>
<td>BG as research method; GP defenses</td>
<td>typology of 5 potential harmful GP roles (in which the GP perform a heroic function): description + example</td>
</tr>
<tr>
<td>Dahlgren et al. 2000</td>
<td>semi-structured interviews with 3 BG participants (physiotherapists)</td>
<td>interpretative phenomenological approach (metaphors)</td>
<td>? (1x/mnth - ? - 18 mnths)</td>
<td>process; effects</td>
<td>8 process elements grouped into 4 phases (e.g. expression of difficulties, meeting other perspectives, learning, applying to practice)</td>
</tr>
<tr>
<td>Graham et al. 2009</td>
<td>semi-structured interviews with 17 BG participants (psychiatric residents and counsellors)</td>
<td>description</td>
<td>16 hrs (1x/wk - 1 1/4 hrs - 12 wks)</td>
<td>evaluation; process; effects</td>
<td>evaluation: groups were anxiety provoking; process: e.g. group container, self-reflection; effects: e.g. understanding case dynamics, awareness of own and patient’s feelings, new perspective/conceptual framework</td>
</tr>
<tr>
<td>Kjeldmand &amp; Holmström 2008</td>
<td>semi-structured interviews with 9 BG participants (GPs)</td>
<td>phenomenological analysis</td>
<td>part. from diff groups</td>
<td>process; effects</td>
<td>process: sense of security, parallel process, endurance &amp; satisfaction; effect: competence in the physician-patient encounter, recognizing different aspects of professional identity</td>
</tr>
<tr>
<td>Kjeldmand &amp; Holmström 2010</td>
<td>semi-structured interviews with 8 BG leaders</td>
<td>systematic text-condensation method</td>
<td>part. from diff groups</td>
<td>leadership; process</td>
<td>3 categories of difficulties in BGs: 1) related to individual member, 2) related to group/leader, 3) related to group surroundings</td>
</tr>
<tr>
<td>Merenstein &amp; Chillag 1999</td>
<td>observation of 14 BG sessions (field notes); interviews with 10 BG leaders; 7 focusgroups with BG participants</td>
<td>editing style</td>
<td>part. from diff groups</td>
<td>leadership</td>
<td>comparison of different BGs in terms of format, themes discussed, dynamics, leadership</td>
</tr>
<tr>
<td>Pinder et al. 2006</td>
<td>observation of 6 BG &amp; 2 non-BG meetings (field notes; interviews with 13 participants (GPs - registrars); discussion with leaders)</td>
<td>ethnographic approach / case studies</td>
<td>part. from diff groups</td>
<td>process; evaluation</td>
<td>process: group dynamics; evaluation: positive and negative experiences</td>
</tr>
<tr>
<td>Samuel 1989</td>
<td>tape records; leader’s notes; report by 11 BG participants (pre: expectations; post: evaluation, change of others); group attitude questionnaire by 11 participants (pre + post)</td>
<td>description</td>
<td>90 hrs (1x/2wks - 1.5 hrs - 2.5 yrs)</td>
<td>themes; doctors’ defenses; process; effects; evaluation</td>
<td>themes: often personal themes; process: identification with cases, use of group for immediate help in daily work; effects: maturation of defenses, some change in attitudes towards group and patients, little sensitivity towards other members’ change</td>
</tr>
<tr>
<td>Torppa et al. 2008</td>
<td>leaders’ notes on 2 BGs (medical students)</td>
<td>grounded theory</td>
<td>15 hrs/7.5 hrs (1x/2wks/1x/wk - 1.5 hrs - x 10/5)</td>
<td>themes</td>
<td>themes: e.g. feelings related to patients, building professional identity, negative role models, cooperation with other medical professionals</td>
</tr>
<tr>
<td>Van Roy et al. 2014</td>
<td>observation notes; tape records + transcripts of 2 case discussions in 2 BGs (GPs + mixed)</td>
<td>description</td>
<td>part. from diff groups</td>
<td>process</td>
<td>process: characterisation of change in participants in 2 case discussions</td>
</tr>
<tr>
<td>Study</td>
<td>Methodology</td>
<td>Participants</td>
<td>Duration</td>
<td>Evaluation</td>
<td>Effects</td>
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</tr>
<tr>
<td>Musham &amp; Brock 1994</td>
<td>Semi-structured interviews (retrospective) with 16 BG participants</td>
<td>not mentioned</td>
<td>&gt; 24 hrs (1x/wk - 1 hr - &gt; 6 months)</td>
<td>evaluation</td>
<td>effects</td>
</tr>
<tr>
<td>Parker &amp; Leggett 2014</td>
<td>Unstructured written feedback from 16 participants (medical students)</td>
<td>Thematic analysis - grounded theory</td>
<td>6 à 8 hrs (7 - 1 hr - 6 à 8 wks)</td>
<td>evaluation</td>
<td></td>
</tr>
<tr>
<td>Bacal 1971</td>
<td>Qual: interviews with 12 participants (GPs) (post)</td>
<td>Qual: not mentioned + Quant: Kendall's correlation</td>
<td>part. from diff groups</td>
<td>outcome: defining change (pilot study)</td>
<td>criteria for change: knowledge of own limits + minimal interference of own psychopathology</td>
</tr>
<tr>
<td>Johnson et al. 2004</td>
<td>Qual: open evaluation forms + focus groups with 21 BG leaders; Quant: evaluation forms</td>
<td>Qual: grounded hermeneutic editing approach + Quant: principal components analysis</td>
<td>part. from diff groups</td>
<td>leadership</td>
<td>5 essential leadership skills: creating safe climate of safety, guarding over group norms, encouraging group movement, understanding group process, personality/style of leader</td>
</tr>
</tbody>
</table>

**Legend**

**: Time in BG: approximate number of hours calculated by multiplying mentioned session frequency (x/week or x/month), session length (hours) and overall duration of Balint group (weeks, months or years) (possible holiday breaks could not be taken into account, thus for the longer lasting groups the calculated numbers may be slightly overestimated).
observed a change in attitudes towards the group and patients and, similar to Abeni et al. [43], a maturation of defenses.

**Characteristics of Balint group participants**

Five quantitative studies [5, 21, 50, 53, 56] compared BG-participants with non-BG-participants on several characteristics. Dokter et al. [53] compared a broad group of personality characteristics called “Balint characteristics”, personality traits and perceptions of patients in a group of Balint participants versus a control group, but the results do not allow for general conclusions. Cataldo et al. [21] found no significant differences in empathy or in overall work satisfaction between BG participants lasting in the BG for two years and participants who left after the obligatory 6 month participation. Kjeldmand et al. [50] found that experienced BG participants (>1,5 years) had significantly higher scores on self-reported control, satisfaction, quality of work, co-operation, training, health and attitudes towards psychosomatic patients than GPs with no BG experience. Finally, although relying on a very small sample, Joukamaa, Lehtinen and Karlsson [56] deduced that BG participants showed lower ability to detect patients' mental disorders than non-BG-participants.

**Themes – Process**

*Themes.* Several studies reported on the themes that were addressed during BG sessions. However, Torppa et al. [34] were the only authors to present a systematic overview of themes addressed in (student) BGs, which are illustrated with examples. The majority of papers provide only a brief (non-systematic) grasp of some of the themes that were addressed [11, 13, 15, 19, 25, 28, 35, 41, 46, 49, 57-59]. Brock and Stock [52] provide an overview of the frequency with which specific themes are addressed in BGs. As general trends, Samuel [55] observed that themes often represented a personal involvement with particular kinds of problems and von Klitzing [13] observed a tendency for participants to present terminally ill patients that were similar to themselves with regard to gender and age.

*Process.* Seven qualitative articles [4, 6, 7, 16, 55, 60, 61] investigated the process of BG meetings or BG participation (i.e. the way BG participation might lead to certain effects).
Dahlgren et al. [16] investigated participants’ descriptions of the BG process and described eight elements grouped into four phases (e.g. expression of difficulties, meeting other perspectives, learning, application to practice). Graham et al. [4] described pathways through which change in BG participants occurred, pointing at aspects such as the group’s container function or the process of self-reflection. Kjeldmand and Holmström [6] pointed to a sense of security, parallel processes and the recognition of participants’ professional identity as some of the group processes at work. Samuel [55] noted that participants often identified with each other and their patients in the case discussions and that they often used the group for immediate help in daily work. Pinder et al. [61] pointed out helpful as well as limitative group dynamics by making use of detailed case examples. Kjeldmand and Holmström [60] touched upon potentially negative group processes such as scapegoating. Starting from Lacanian theory, Van Roy et al. [7] focused on two BG cases and described the participants’ process of change. Furthermore, two quantitative studies [13, 43] investigated BG processes. Over the course of several sessions, Abeni et al. [43] found significantly increased group engagement and decreased group conflict, but this was only the case in a group of caregivers. Finally, using word counts in session transcripts, von Klitzing [13] observed that participants’ verbal activity and their reflections about their patients increased, whereas reflection about themselves decreased.

**Leadership**

Five articles focused on leadership-related issues by making use of either a qualitative methodology [49, 60], a mixed qualitative-quantitative methodology [62] or a quantitative methodology [48, 52]. Nearly all studies started from leaders’ perspective on leadership. Kjeldmand and Holmström [60] focused on leaders’ experiences of difficulties in their groups, while Johnson et al. [62] extracted five essential leadership skills from BG leaders’ evaluation forms and focus groups (creating safe climate of safety, guarding over group norms, encouraging group movement, understanding group process, personality/style of leader). Relying principally on observations of several BGs, Merenstein and Chillag [49] touched upon several leadership-related issues (e.g. personality of leaders, degree of hierarchy, degree of control). Brock and Stock [52] (with a follow up by Johnson et al. [48]) quantitatively investigated leaders’ perceptions of group objectives, format, issues, attitudes
or skills attainable through BG participation and leaders’ professional backgrounds. Group objectives and leaders’ professional backgrounds were later reassessed by Johnson et al. [48], who also included data on leaders’ training.

**Evaluation of group – attendance**

*Evaluation.* Some papers focused on participants’ evaluation of their participation in a BG by using qualitative interviews [4, 5, 61], qualitative written reports [32] or quantitative questionnaires [28, 31, 32]. Some of them described rather positive group evaluations. For instance, Sekeres et al. [28] reported that the residents evaluated the groups as safe, as an opportunity to decompress, and as a social outlet. Other authors outlined participants’ negative experiences, especially in mandatory groups: Graham et al. [4] reported that residents participating in a BG experienced the groups as anxiety provoking and that some struggled to adapt to the learning process, the latter corresponding with Musham and Brock [5] who observed participants’ initial poor understanding of the purpose of the groups. Finally, some papers reported mixed findings. Although somewhat tentatively, Parker and Leggett [31, 32] mentioned participants’ rather positive evaluation of individual group sessions, whereas participants were more hesitant about the relevance of the groups to their clinical practice. Pinder et al. [61] provided detailed group evaluations (including both positive and negative aspects) by interviewing the presenters after the group meetings.

*Attendance.* A number of articles focused on participants’ attendance to Balint groups. In some countries a limited time of BG participation (mostly 6 months) is mandatory for residents. After this period residents are offered the opportunity to continue their participation or not. Some studies (e.g. [21, 23]) compared residents who do not continue their BG participation after 6 months (labeled ‘non-attendees’) to those who continue participation for 2 years (labeled ‘attendees’). Johnson et al. [23] found a proportion of 35% ‘non-attendees’ and this group was less intuitive than the group of ‘attendees’; however, this was the only difference in a large amount of personality traits measured at the start of BG participation. Comparing ‘attendees’ with ‘non-attendees’, Cataldo et al. [21] found no significant difference in empathy or work satisfaction. Dokter et al. [53] compared ‘stayers’ and ‘drop-outs’ with regard to “Balint characteristics”, but failed to provide the
underpinning statistical data. One qualitative analysis of participants’ reasons for infrequent attendance pointed out factors such as time, discomfort and not being convinced of the relevance of BG work to their clinical work [5].

**Historical-geographical articles**

Two studies presented a number of facts about US BGs. Brock and Stock [52] conducted a survey study offering data about existence, leadership, meeting frequency, objectives and composition of BGs in US family practice residencies, with a follow up study ten years later in 2000 [48]. Other, non-empirical articles provide historical information about the introduction of BGs (the initial groups by Michael Balint as well as other groups) and about Balint societies [2, 3, 15, 47, 63-68].

**Reports – anecdotal articles**

A large part of the non-empirical papers are reports about BGs. Often they consist of (co-)leaders’ or participants’ BG experiences, but sometimes the author’s relation to the BG is not specified. They often comprise detailed information about BG meetings (e.g. [17, 40]), initiatives of setting up BGs (e.g. [66]), difficulties encountered (e.g. [37]), issues addressed (see Themes), interventions applied (e.g. [26, 46]), instruments used (e.g. “initial interview card” [69]), a group’s evolution (e.g. [15, 20, 24, 25, 37]) or group evaluations (e.g. [14, 18, 25, 29, 30, 70]). Sometimes the reports describe specificities of BGs for special target groups or specificities about ‘modified BGs’ (see 3.3). Some papers also offer case examples, which either serve as a mere illustration (e.g. [29, 30, 57, 71]), or are further analyzed in the paper (e.g. [14, 17, 24, 36, 38, 39, 69, 72-77]). One paper consisted of an (excerpt of a) transcript of a BG meeting [78].

**Reflective articles**

In a substantial number of the non-empirical papers, the authors discuss and reflect on diverse BG related topics. The depth of reflection was found to be variable over the
different papers: some articles mainly present different aspects of what BG work is, whereas others provide a critical reflection about specific Balint-related issues. In this section, we present the topics that are most frequently discussed. Some papers give thought to the need for Balint training and its place in (continuing) medical education (e.g. [71, 72, 79, 80]), the role of mandatory groups (e.g. [81]) and the future of BGs (e.g. [47]). Several papers focus on the specificity of BGs (e.g. [82-86]), comparing them to other forms of group discussions (e.g. [87-89]), discussing the possibility of BGs for other professions (e.g. [75]) or the necessity to adapt BGs to the participants’ needs (e.g. [26, 58]). Some papers reflect on change that BG participation might facilitate (e.g. [69, 71, 90]) or leadership issues (e.g. [33, 39, 66, 75, 85, 91, 92]). In certain papers, the authors use theoretical concepts as a framework for understanding BG processes (e.g. [73, 86, 91, 93, 94]).

**Balint group observation as research data**

Michael Balint introduced his seminars (later called ‘Balint groups’) as “training-cum-research” groups [82]. This means that these seminars not only aimed to ‘train’ GPs, but also to investigate, as a group, aspects of general practice. In line with this mode of proceeding, some papers discuss the use of BGs as a research method (e.g. [69, 72, 84, 95]). Some studies actually used BG observations as research data to study specific GPs’ characteristics, e.g. GPs’ defenses [55, 96] and ideas on the phenomenon of ‘third party in general practice consultations’ [44]. Bourne and Lewis [64] reflected upon the involvement of BGs in such research projects. The scientific value of BGs was questioned by Sowersby [97].

**DISCUSSION AND CONCLUSION**

**Discussion**

This literature review demonstrates that only a limited number of peer-reviewed articles concerned with BGs have been published. We note a slight rise in the number of articles published over the years, but compared to the increasing scientific publication trends, this is perhaps to be considered a relative decrease [98]. Moreover, apart from the
empirical articles (n = 35), their methodological strength was also generally low. This was related to several shortcomings (see Table 1). For instance, there is an overall trend of using very small samples. This could be partly due to the relatively low number of existing BGs [3]. However, difficulties finding participants do not justify the omission of a control group, of using longitudinal designs (which is a minimal requirement for outcome studies), and of commenting on the reliability and validity of instruments used. Nor does it justify using statistics in an incorrect way (e.g. providing no information on the significance of results) or presenting results in a misleading way (e.g. presenting the results incorrectly in the abstract). Unfortunately, these critics apply to many research articles [99].

Given the fact that the included papers deal with different research topics and that several studies were inconclusive, general conclusions cannot be drawn. Nevertheless, we identified broad research topics that were repeatedly addressed. These included diverse outcome variables, BG participants’ characteristics, BG themes and processes, leadership issues, evaluations and attendance. For instance, several outcome variables (such as psychosocial self-efficacy, burnout and change in attitudes) were investigated but overall there was no convincing evidence on any variable. Apart from the low number and methodological weakness of articles, this can be additionally explained by the difficulty of defining the outcome measures that may grasp the “limited but considerable change” as referred to by Michael Balint [1]. However, despite these shortcomings, certain (qualitative) effect and evaluation studies as well as reports and reflective articles give clear indications of the possible value BGs may still have today. Moreover, research on BG process and leadership revealed interesting insights, but integration and further exploration of these ideas is recommended. Therefore, further critical reflection (as opposed to dogmatic repetition of certain ideas) concerning BGs is needed, both for practical purposes and to reflect on future research designs and topics. For instance, adopting a critical stance might be advanced by joint cooperation between professionals involved in BG work and external researchers (e.g. as is done in [49, 61]). Moreover, this type of discussion as well as explorative (qualitative) research may also contribute to defining useful variables (e.g. [54]), that may be used in further research.
Limitations

There are limitations to this literature review. As mentioned above, only English-language articles were included, though a large number of articles in other languages are available. Reviewing these articles and contrasting them with the current study might be an interesting undertaking. Moreover, books (e.g. [1, 100, 101]), conference proceedings and articles in national Balint society journals were not taken into account. Furthermore, given the occasionally flexible distinction between what is a BG and what not, it is possible that papers using different names for their groups were missed. Finally, word count restrictions obliged us to tightly synthesize nuanced research findings.

Practice implications

Through this review study, certain points of interest for both professionals involved in BG work and (future) BG researchers emerge. First, since some papers reported effects (e.g. psychosocial self-efficacy, burnout) only after long-term BG participation [11, 12, 50], BGs should be organized for a sufficient length of time (1 or 1.5 year at least) to allow for change. Furthermore, given the repeatedly stressed importance of good leadership, further investment in leaders’ training as well as examination of leadership related issues is highly recommended. Next, the topic ‘modified BGs’ repeatedly came to the fore in our study. This leads us to the broader issue of what the core of BG work is and what may be fruitful adaptations. This applies for instance to BGs for students/residents who may have particular needs, a topic that is discussed by some authors (e.g. [26, 31]). In order to stimulate meaningful discussions and reflections on this topic, articles should supply information about proceedings, goals, group composition, leaders’ profession and authors’ relationship to the BG. Further considerations to researchers comprise setting up well-considered study designs. To that end, learning from previous research designs and output is recommended, a task that this review might facilitate. As already noted, defining appropriate variables is an important difficulty to manage. To this end, pilot studies, genuine reflective or theoretical papers addressing this issue and thorough qualitative research may be instructive. Furthermore, in order to minimize bias, triangulation of self-report data with other data is advised. As suggested by other authors (e.g. [61]), this could comprise the inclusion of
patients’ perspectives or consultation observations into BG research. Focusing on qualitative research might meet the difficulty of finding sufficient numbers of participants to allow for statistical conclusions. In order to perform high quality qualitative research, it would be recommendable to use a qualitative research checklist, such as NICE guidelines [9]. Valid research findings may not only help BG workers to enhance their practice, it could also help policy makers to make more informed and appropriate decisions.
REFERENCES


A Lacanian view on Balint group meetings: a qualitative analysis of two case presentations

In this chapter, we aim at getting a more profound insight into what exactly happens in Balint group meetings. To this end, we scrutinized two Balint group case discussions at a micro-level and focused on the process of change that could be observed during the Balint group meetings. We used Lacan’s theoretical distinction between imaginary and symbolic modes of relating to the other as the framework to shed light on the evolution that characterizes the presenter’s narrative. In both case discussions, the GPs presenting the case initially appeared to be stuck in a fixed image of a situation, referred to as ‘imaginary relating to the other.’ Through a range of interactions with the group, the presenters were encouraged to explore different subject positions, which allowed them to broaden their initial image of the situation and to discover other issues at stake. This was referred to as a more symbolic way of relating to the other.

BACKGROUND

While guidelines increasingly assist general practitioners (GPs) in making decisions with regard to medical diagnosis and treatment, less attention is given to their subjective experience and interpretation of clinical situations. Nevertheless, it is said that GPs “have to make decisions about what to say, what to treat, what to ignore, what to observe, what to reflect about and what to turn their backs on” (1979: 470) [1]. Consequently, apart from a vast amount of medical knowledge and technical expertise, they also use themselves as instruments in diagnosis and therapy [2]. In order to use themselves more effectively in their work, Novack et al. [2] suggest that physicians should “calibrate their instruments,” i.e. their own subjectivity. Among other methods of work-related self-reflection [2], Balint group work provides physicians with opportunities to explore and articulate their own subjective involvement in their everyday work [3,4].

Balint groups were first set up in the 1950s in London by the psychoanalyst Michael Balint [3-5]. These groups were designed to offer GPs a platform to explore difficult interactions with patients by means of case presentations and discussions. Since that time, Balint groups have been set up worldwide, albeit on a small scale [6]. Some groups are exclusively for GPs, whereas others also welcome other professionals from the (para)medical field (e.g. [7-10]). Typically, Balint groups comprise six to twelve participants and one or two leaders (also referred to as animators); meetings usually take place on a once- or twice-monthly basis over several years. The meetings start with a participant’s case presentation, which generally reflects a difficult interaction he/she has had with a patient. The case presentation is then followed by a group discussion that focuses on the thoughts, emotions and subjective reactions that the presentation evokes [11,12]. Generally, in one meeting, two cases are presented and discussed. Balint group meetings aim to stimulate a process akin to psychoanalytic ‘free association.’ Therefore, participants are asked to present cases without using notes or case files [3] and all group members are encouraged to share their ideas, associations, images and emotions evoked during the discussion. This way of working facilitates alternative viewpoints that may redefine the initial problem. Moreover, by speaking freely, members can become aware of their unconscious attitudes towards the patient or the situation in a way that helps them recognise their own implication.
Research on Balint groups is relatively scarce. Only a limited number of studies examine the actual process of Balint group case presentations and discussions (e.g. [8,10,13,14]). Whereas Michael Balint believed that long-term participation in such groups could lead to “a limited, though considerable change in the doctor’s personality” (1964: 299) [3], it remains unclear as to what kind of change takes place in the mind-set of clinicians who participate in these groups. In the present study, we examine the potential benefit of Balint group work by exploring the process of change on a micro-level. Through a detailed examination of two Balint group case discussions, we study the change that takes place in group members’ perspectives. Therefore, we use Jacques Lacan’s theoretical distinction between imaginary and symbolic modes of relating to the other.

**Lacan’s theory on imaginary and symbolic relating to the other**

Jacques Lacan (1901-1981) was a French psychoanalyst who re-examined Sigmund Freud’s work, bringing it into dialogue with linguistics, mathematics, structuralism and other disciplines [15]. Given the fact that subjectivity, discourse and the unconscious are central concepts in Lacan’s theory, it was deemed an excellent reference frame for this study’s purpose. More specifically, we used Lacan’s distinction between imaginary and symbolic modes of relating to the other to guide us in analyzing the data. Lacan [16] discusses the roots of this *imaginary relation* in his theory of the mirror stage. This theory states that early in life, due to a lack of sensory and motor coordination and the primitive organization of libidinal life, the infant’s self-experience is fragmented, and only gradually becomes organized through the recognition of a self-image in the outside world. By means of ‘mirroring’, i.e. discerning self-images or images of others as mirror images, the child identifies with a body image that it regards as its own [17]. For Lacan, the mirror phase coincides with the inauguration of the *ego*. This type of identification is not restricted to infancy, but is continues throughout one’s life [18]. Imaginary functioning is efficient in that it allows people to understand each other. For instance, when we are ill and decide to consult a doctor, we identify with the role of patient. In this context, the doctor functions as a mirror in which we see ourselves as a patient. In other words, the patient needs the doctor in order to assume his role as a patient, and vice versa. This implies that human beings do not so much acquire an identity by assuming certain characteristics, but by ascribing
characteristics to someone else and by positioning themselves in relation to such characteristics [19]. It is indeed in the interaction with others that identity is developed [20]. As mentioned above, the ego provides us with a sense of unity. However, this feeling is “an illusion that blinds us to what does not fit the image” (2009: 396) [17] and at times favours a one-dimensional view of situations. Moreover, in imaginary relations, everything can be played out in terms of the opposition: same or different [21], which possibly results in power struggles.

While imaginary identification has an organizing role in mental life, Lacan [16,22,23] stresses its accompanying tendency for misrecognition: it masks the heterogeneity of the subject through sustaining a sense of self-unity [16]. The symbolic relation, by contrast, starts from recognizing the otherness of the other (i.e. ‘the other does not coincide with the image I have of him/her’), as well as one’s own dividedness (i.e. the subject is divided across different identifications). These characteristics distinguish the subject from the ego. From a Lacanian point of view, the subject is an effect of the fact that we speak; it is “multiple, contradictory and not entirely rational” (2005: 76) [24]. As a result, subjectivity is "seen as complex, distributed and fragmented, permeated by social and discursive processes, yet intimately personal, as the subject invests these processes with desire and turns them to the very stuff of his or her being” (2009: 655) [25]. The symbolic relation implies an openness for exploring and naming the multiplicity that characterizes the subject-dimensions or subject positions [26]. The underlying idea is that repressing the subject eventually results in symptomatic behaviours and complaints, as well as in problems at the level of imaginary functioning (e.g. power struggles).

To our knowledge, Lacanian theory has not yet been applied to an analysis of Balint group functioning. However, we believe that using the theoretical framework outlined above can offer new insight. Given the centrality of both speech and social interaction in Balint groups, focusing on imaginary and symbolic relations can help us depicting the process of change that takes place in Balint group discussions. Indeed, problems brought forward in these discussions are often examples of how a GP has become stuck in a fixed image of a situation (see also [27]). As outlined below, the change induced in Balint group discussions often coincides with a change in perspective from ego to subject, paving the way for a symbolic rather than an imaginary mode of relating to the other.
METHODS

Procedure

The data used in this study are part of a larger data set gathered in the context of a PhD project on GPs’ experiences with their practice. For this larger data set, the first author, a female researcher with a degree in medicine and psychology, observed monthly meetings of four Balint groups over a 15-month period (April 2011 – June 2012). In total, 45 meetings (87 case discussions) were observed; from these, 33 meetings (68 case discussions) were audio-recorded. Three groups were located in Wallonia, the French-speaking region of Belgium, and one in the Netherlands. In two groups all participants were GPs; the other two groups were mixed (including GPs, physiotherapists and nurses).

Following each Balint group meeting, the observer noted down descriptions of the case presentations as well as reflections on the dynamics of the group discussion. From these observations, we noticed that many meetings were characterized by a marked ‘change’ in the presenter’s discourse on the presented doctor-patient situation. In order to further examine the observed process of change, two audio-taped case presentations were selected from the larger dataset and were transcribed verbatim. Both cases were considered typical and thus representative for the majority of the observed meetings. Moreover, the second case was considered highly instructive due to the marked change in the presenter’s discourse during the case discussion as well as the remarkably positive case follow-up. Transcripts were studied by the six members of our research team (KV, SV, VD, RI, RM and JD), all clinical psychologists. It was agreed upon that in both cases, the presenter’s discourse changed substantially throughout the respective sessions. This study was approved by the Ghent University Committee for Medical Ethics.

Participants and sample

The selected presentations were selected from two relatively similar Balint groups. Each group met once a month in meetings lasting between two and two and a half hours; they both had eight to ten participants; both groups were gender-mixed and the members’ mean age was 46 years in one group and 52 in the other. Whereas in one group all
participants were GPs, the other group also comprised other professionals, such as nurses and physiotherapists. The mean number of years of participation in these Balint groups was approximately 4.5 years (range 1 to 10 years). Both groups were led by two animators, who were GPs or psychologists with a training in psychoanalysis. The presenters of the cases below were both female GPs, who had been participating in their respective Balint groups for several years.

Data analysis

The data-analysis consisted of two major parts. In the first phase, we coded the transcripts inductively, remaining very close to the participants’ words. The transcripts were first subdivided into fragments, each covering a different idea that was brought up in the Balint group meeting. At the same time, this allowed us to mark turning points in the discussion. Later, the ideas were categorized in broader themes that each reflected a different focus on the difficulty that was presented: focus on patient as a person, focus on patient’s situation, focus on GP and focus on doctor-patient interaction. Apart from a first analysis of the content, we also coded the group interventions (e.g. ‘challenging presenter’s expression’, ‘informative question’, ‘providing opinion’, ‘introducing new perspective’). The authors first studied the transcripts separately and subsequently consulted with each other to discuss the patterns of change that appeared in the data. As patterns of change were discussed, it was decided to make use of Lacan’s theoretical distinction between symbolic and imaginary relations. Applying this conceptual framework to the data, we started the second part of the data-analysis. By identifying the switches from imaginary to symbolic relating to the other, and by analyzing the group interventions that were associated with these, an overarching idea on the kind of change Balint group discussions provoked in the mind-set of the clinician came to the fore. More specifically, this part of the analysis was performed with two main focuses. On the one hand, it was guided by a continual reflection on the position each presenter is speaking from and the position that is attributed to the other, i.e. the patient. On the other hand, we focused on the language used by each presenter. We mapped the evolutions in the subject positions expressed by each presenter, as well as the group interventions that contributed to these evolutions.
RESULTS

Case 1 – ‘The dismissed shock absorber’

In response to the animator’s routine question as to who would like to present a case, one female GP was keen to present a situation. She reminded the group that she had wanted to present this case in the previous meeting and stated: “Well, and I still have this situation, with new developments because I am dismissed.” It should be mentioned that it was only later in the discussion that the meaning of this statement became clear to the other group members (i.e. the patient had ‘dismissed’ the GP). The group immediately agreed to hear more about this case, and the presenter went ahead:

“The first time I saw this lady, completely accidentally, she called me saying that she needed a doctor because she didn’t feel well. So, I arrive [at her place], she’s lying on a mattress in a room in a working-class house, and she’s obviously suffering from an anxiety attack. And so, I talk to her for a while and then, well, apparently, she thinks that she’ll have me as her doctor. You should know that this lady lived in that house, I mean apartment, that the apartment was rented by her companion of the moment, and that at that moment, there were three or two children in the apartment which had only two rooms....”

These introductory phrases provide a good sketch of the presenter’s initial report of the case, which proves to be highly anecdotal and strongly focused on the patient’s complex and chaotic situation. This initial presentation illustrates how this GP was somewhat stuck in a restricted perception of the situation. On the one hand, her discourse predominantly focused on the patient and, in particular, the patient’s way of living; her ideas and questions on the role she played (i.e., the presenter’s difficulties and feelings) were, by contrast, left almost unmentioned. On the other hand, the abundance of details and anecdotal information contrasts with the scarcity of meta-reflection on the situation. The presenter frequently used passive formulations (e.g. “I am dismissed”; “she’ll have me as her doctor”), which reflect well her feelings of being overwhelmed by the situation.
After a while, one animator intervened by inviting the presenter to talk about her own position in the situation she just presented. Indeed, the presenter had not elucidated the reason(s) for presenting this case, nor had she formulated some kind of question towards the group. Clarifying this was found to be commonplace in most of the Balint group meetings that we observed. The focus of such elucidation or question (e.g. whether on the patient’s problem or on the presenter’s own difficulty) can provide a first impression of the presenter’s perspective and acknowledgement of his or her subjective implication in the situation. In this presentation, such clarification was not spontaneously offered by the presenter. Moreover, she proved to have difficulties to react to the animator’s intervention, providing more anecdotal information about the patient instead. Throughout the discussion, group members made numerous attempts to encourage the presenter to express her reasons for presenting this case, either through direct questioning (e.g. “And how are you yourself situated in this story?”; “What is bothering you?”) or suggestions (e.g. “I don’t know what your question is, but I want to say, I have some difficulties with therapeutic ruptures”; “Maybe this [feeling of it being a tough situation] is the reason why she presented the case”). The presenter’s reactions to these questions and suggestions further illustrates how she is somewhat absorbed in the situation and has difficulties verbalising her subjective position (e.g. “it has always been a complex situation”, “it really deteriorated”, “I wanted to know whether you can provide me with some ideas about how I could have avoided being taken in by that inextricable situation”).

The group members’ interventions consisted of a mix of questions and invitations for reflection on the one hand, and of ideas and suggestions that open up additional perspectives on the case on the other hand. Some interventions, for instance, aimed to stimulate the presenter’s reflection on the doctor-patient interaction. For example, when a group member posited that they must have had some kind of bond during all those years, the presenter reported how she had been communicating with the patient by means of a notebook for some time, and the difficulties this eventually evoked for the patient. Later in the discussion, one group member asked: “I was wondering how you relate to each other, like a woman accomplice to a woman, like a sister (...)? Well, in fact [this comes down to] how you imagine your relationship [with this patient] functions for her. Like a mother? Or like what?” Interestingly, these suggestions triggered a recollection in the presenter about
the patient calling her a friend. She referred to a situation where this patient had asked her for money “as a friend.” Here, the presenter herself did not spontaneously explore the role the patient had attributed to her, yet the group picked-up on this, guiding and inviting the presenter to occupy a different position.

Other group interventions addressed the presenter’s tendency towards rationalisation as well as the scarcity of affective references. On the one hand, the group challenged the presenter’s propensity to rationalise situations by questioning the assumptions underlying her rationalisations. For instance, the presenter’s conviction that a medical centre is more structured than a private practice was repeatedly put into question by several group members. On the other hand, the group actively engaged in the affective dimension. By verbalising their own affective states, either in relation to the situation (e.g. “It's an impossible situation”; “It's lost from the beginning”), in relation to the patient (e.g. “I like her, I find her dynamic”), or in relation to the presenter (“I think you’ve come a long way with her”), the group actively introduced a supplementary range of subject positions. Some of these comments prompted the presenter to verbalise fragments of her own affective implication in the situation. For example, one group member’s comment that “she [the presenter] has done a lot for her [the patient]” makes the presenter claim “it’s true, I’m sure,” adding “too much” and “I didn’t protect myself enough.” This remark possibly indicates a subtle change in the presenter’s perception of the doctor-patient relationship: the presenter finally appears as someone who does not merely endure a situation, but as someone who actually has a choice with regard to how she can react to the situation.

The interactions outlined above reflect how members of this Balint group jointly created different perspectives on the situation that was presented: group members helped the presenter to transcend her immediate way of perceiving the situation and to explore it from other subject positions. For instance, this became apparent through a remarkable re-definition of the doctor-patient relationship. Whereas in talking about the doctor-patient relationship, the presenter repeatedly used expressions reflecting an employer-employee context (e.g. “I am dismissed”; “she’ll have me as her doctor”; “she fired me”; “she imposed a timetable”), one group member’s remark concerning the position a GP can occupy in such complicated cases led the presenter to reframe her position: “Maybe I was too much of a shock absorber.” The shift to a different semantic frame as well as the presenter’s active
formulation of her own position may indicate her subjective position had been affected. However, other opportunities to articulate new subject positions were not taken up by the presenter. For example, when a group member commented on the fact that she had lent money to this patient, defining this as a boundary he would never cross, the presenter emphasized that she only did so with this patient. This statement prompted an animator to ask “But what does she evoke? What has she evoked that makes you say I only did this with her? (...) It is something very strong, isn’t it?”. While this reaction invited the presenter to elaborate on the way she is affected by this patient, she did not follow the animator’s prompt, but merely referred to what the patient needed the money for. This illustrates how the presenter only partly engaged in the acknowledgement of her subjective position in relation to the patient.

Apart from immediate alterations in the presenter’s discourse, another indication of the change that the group discussion evoked can be found in the case follow-up, which usually takes place during the next Balint group meeting. Although the presenter had no subsequent professional contact with the patient (the patient had ‘dismissed’ the GP), there had been a brief encounter which the presenter discussed with the group. On the one hand, she continued to engage in a rather unaffected and passive mode of storytelling. She commented upon a moment when she had seen the patient in the street, using phrases such as “I thought I was immune”, “One would like to have some news” and “I say to myself, well, she hasn’t contacted me yet.” On the other hand, she also attempted to verbalise how she felt when she met the patient in the street: “But I made the reflection..., I can’t explain exactly what the feeling was like, but it was not a pleasant one. Whereas I thought I was immune, I wasn’t. (...) Seeing her like that, I had a strange..., a malaise, I don’t know, really a malaise.” Moreover, referring to the fact that she is not in the position to solicit information about the patient from other professionals, she defined herself in more active terms (“I have detached myself from it”). Her hesitant search for a suitable expression (showing ambivalence and indeterminacy) and the additional focus on her own emotions indicate that the discussion had had an effect on the presenter’s perspective, helping her to transcend the imaginary mode of relating to the patient, in which she appeared to have been the passive victim of the other.
Case 2 – ‘The escaping approacher’

Following an animator’s question as to whether anybody had a case to present, the group remained silent for a while. Finally one female GP stated: “I have a case.” After checking whether anybody else wanted to present a case, the animator passed the floor to this GP. She began with a brief description of the patient (an 80-year old widow living in a nursing home), followed by an account of their first meeting:

“And so, I go and meet her for the first time, and our first interaction was rather peculiar. I introduce myself, and immediately, things are complicated: I called her by her maiden name [upon which she objects:] ‘No, no, no (screaming), that’s not how I’m addressed, I’m called Mrs Blah Blah Blah.’ Moreover, it’s a long and hyper-complicated name. I say to her: ‘Alright, ok.’ [She goes on]: ‘For 40 years I’m Mrs Blah Blah Blah, and so, you should address me that way.’ Ok, alright. ‘Because, you know, I’m the daughter of a statesman, Mr Blah Blah Blah.’ Actually, she’s a patient from (country), who has been living here since she was married, so for a really long time. She was married to a statesman, or something like that, all of her grandchildren are politicians. Well, so I say to myself, it’s rather peculiar to talk to me like that, but, well, maybe she is somewhat confused. So then we started talking, but I thought it was peculiar because I found her a real snob, a real snob. Appearances are hyper-important [to her], she told me 40 times she was the daughter of a statesman.”

This fragment illustrates well this GP’s general style of reporting during her initial case presentation. Unlike the previously discussed case presentation, this one is clearly marked by affectivity. The presenter’s sense of irritation is tangible through the examples she used to describe the patient (e.g. the patient’s insistence on being called by her marital name), through her tone of voice as she mimicked the patient’s way of speaking, and through the feelings she expressed about the patient (e.g. “she irritates me”, “it’s unbearable”). In a number of the presenter’s comments, the seeds for conflict escalation within a predominantly imaginary mode of relating to the patient are apparent: her focus on the patient’s aggressive behaviour functions as a mirror in which her own irritation is reflected.
However, the presenter also outlined various attempts to try to understand the patient’s behaviour (e.g. “Well, so I say to myself, it is rather peculiar to talk to me like that, but, well, maybe she is somewhat confused”). At first, these reflections all seem to revolve around her decision as to whether or not the patient suffers from ‘cognitive problems’ without taking into account other possible interpretations. The case presentation ended with the presenter narrating her attempts to go beyond the patient’s hostility by trying to engage her in different topics of conversation, attempts which proved to be vain. She concluded: “I have trouble relating to this patient,” “I don’t know what she is looking for” and “I can’t develop a rapport with her.”

One animator picked-up on these comments to open up the group discussion. A simple informative question (inquiring about the size of the patient’s room) led the presenter to state from a more reflective perspective that indeed the patient’s discourse did not tally with some of the actual facts (e.g. her family’s social standing versus the small room she’s living in). This incongruity was further elaborated by the group, portraying the patient’s situation as “past glory” and “a nineteenth century lady addressing her domestics” and suggesting the possibility that this patient might have been ‘fleeced’ by her children.

By explicitly designating the patient’s behaviour as a role she is taking up, one group member opened up further reflection on the meaning of this behaviour. Several dynamics were suggested: perhaps the patient feels humiliated and that is why she humiliates others; perhaps she is suffering and unable to admit it; the patient might be uprooted; “piquing” might keep her vivid; her behaviour might reflect resistance (against getting old, against her family that put her in the nursing home). In this part of the discussion, new perspectives were jointly constructed: several group members provided alternative ideas for understanding the patient, which were then commented upon by the presenter. One animator denominated these attempts to understand the patient as “a movement of compassion passing through the group.” The presenter then stated, with a notably softer voice: “I would like to approach her, but I have the impression that she won’t let me.” At this point in the discussion, the initial feelings of irritation towards the patient appeared to have been replaced by feelings of ‘compassion.’ On the one hand, this shift might be understood as transgressing the fixity of feelings of irritation; on the other hand, the shift was quite radical and possibly induced another fixed image with a different content. What stands to
the fore is the presenter’s image of the other, which clearly determines her subjective position. Further suggestions supplied by the group (e.g. to compliment the patient; to invite her to speak about her dead husband; to encourage her to be more active in rebuilding a new life) served as cues for the presenter to deepen her understanding of the patient.

However, this changed perspective (from irritation to compassion) did not acknowledge the presenter’s more complex and ambivalent feelings about the situation. When an animator suggested to the presenter to share her concerns with the patient, this ambivalence particularly came to the fore. A renewed flow of irritation was triggered in the presenter, which indicates that her shift in perspective did not address the dimension of symbolic functioning. She reported “not knowing how much she wanted to share with her [the patient],” “not wanting to invest in that person,” and eventually remarked that “she [the patient] just seriously pissed her off.” She resolutely concluded that there are only two options: “either their relationship must end, or something must change.” One animator’s further elaboration on positive aspects of this doctor-patient relationship (e.g. the fact that they are creating a bond; that the GP is adopting the right technique by playing the waiting game; that she might be the patient’s ‘antidepressant’) appeared to actually enhance the presenter’s ambivalent feelings. As she searched for words to verbalise this incongruity, the presenter re-counted her last meeting with the patient, adding a salient detail. Apparently, when the patient had gestured for further interaction (“Are you already leaving?”), the presenter had been thinking that she “just wanted one thing: to escape.” Since the presenter seemed to be unaware of her ambivalence, an animator reflects back the presenter’s comment by stating: “she finally acknowledged you and then you wanted to escape.” The presenter’s initial difficulty to notice the ambivalence she had just expressed might indicate that she was surprised by her own words. At this point, the presenter appeared to be confronted with the otherness in herself, with forces that determine the situation on an unconscious level, or put differently: with her subjective dividedness. By acknowledging her tendency to escape from the patient, the presenter articulated her subjective implication in (the difficulties that characterise) the situation. This acknowledgement of the ambivalence she is confronted with (wanting to approach the patient, while also wanting to escape from her) contrasts sharply with her previous conscious conviction of wanting to develop a bond with the patient.
As this multiplicity of subjective positions was articulated, the presenter took up a more reflective stance, and gained a different perspective on the position she had been occupying in relation to the patient. The group discussion carried on for a little while. In response to one group member’s recapitulation of the discussion, criticizing the lack of exploration of the patient’s actual suffering, one animator emphasized having been impressed by the presenter’s sensitivity to the patient’s affectivity. With this intervention, she redefined the GP’s role as the carrier of a wide range of the patient’s emotions. The final minutes of the discussion were devoted to one group member’s suggestion to introduce some humour into their relationship and to be more playful with the patient.

The case follow-up one month later underscored the presenter’s altered subjective position, which impacted upon the doctor-patient interaction: “I saw her again and in fact, it was weird because the consultation was completely different. Normally it’s quite tense and we don’t succeed in having a real exchange. (...) Now, we’ve been able to have some sort of exchange and, in the end, it was interesting. It was the only time we had a real exchange; for once, it was pleasant. I think the dynamic has changed a little bit, so that’s good, she opened her heart to me, and well, that’s nice.” This follow-up was distinctively positive (e.g. “interesting,” “pleasant,” “nice”). The presenter’s discourse focused on their bond (e.g. “the consultation,” “the dynamic,” “we”) and also included reflective elements on the situation (e.g. referring to the “dynamic” of the interaction, making a comparison with their previous interactions). Remarkably, the presenter appeared to interpret the situation as if the patient had changed (e.g., “she spoke to me about her husband,” “she opened her heart”), which indicates that she is not entirely aware of her own altered position.

**DISCUSSION**

In order to illuminate the process of change in Balint group work, we analysed two case presentations and their subsequent group discussion. We conclude that Balint groups can be considered as a milieu in which GPs, who may be struggling with particular cases, can explore different angles from which these situations can be viewed. Balint group discussions often give rise to reflection that allows the presenters to take into account their subjective position in the relationship with the patient. First of all, the presenters’ willingness to
present a case (in combination with their experience with Balint group work) can be seen as an indication of their readiness to put their perspective into question. Moreover, we believe that the shift from imaginary to symbolic relations is stimulated by the format of the group work. By stimulating free associative speech, the format encourages the presenters to (a) recognize aspects of their own subjectivity that don’t fit their ego; (b) acknowledge aspects of the otherness of the other that didn’t fit with the initial image of the patient; (c) transform their understanding of the problem they are struggling with. The shift towards the symbolic mode of relating to the other is stimulated by responses and interventions of the group members and animators. By asking questions and by articulating ideas, associations, images and emotions that are evoked during the discussion, group members and animators actively encourage the presenter to explore different subject positions. In the two cases outlined above, this shift from an imaginary to a symbolic mode of relating to the patient was observed. In both cases, the presenters appeared to be stuck in a fixed image of a situation (i.e., a chaotic situation that ended with the patient ‘dismissing’ the GP; an irritating patient who was difficult to approach). By verbalising the situation, as well as by interacting with the group, a more heterogenic range of subject positions was articulated. In the first case, the predominant focus on the complexity of the situation was extended with an exploration of the doctor-patient relationship. The presenter was able to take some distance from her spontaneous use of the employer-employee metaphor in depicting the relation with the patient, and to acknowledge the affective charge the situation induced. In the second case, the alternating focus on different patient characteristics prompted the presenter to acknowledge her ambivalent attitude.

Both cases demonstrated the co-constructional aspect of building and rebuilding a perspective with regard to a situation with a patient. The actual ‘change’ that takes place depends on the group’s interventions as well as the presenter’s capacity to take up cues for elaboration. In both groups, various interventions were administered, including challenging the presenter’s perspective, providing additional view points and encouraging reflection on unconscious dynamics that may influence the situation. Focusing on these dynamics, a Balint group meeting can be described as a continuous back and forth movement between providing space for the presenter to elaborate on questions, comments and suggestions, and the active introduction of new perspectives by the group. Depending on the presenter’s
capacity to take up cues for elaboration, the subject positions that determine the GP’s interaction can be opened up. In the first case presentation, for instance, the presenter appeared to be unable to take up certain cues offered by the group (e.g. the meaning of lending money only to this patient), which indicates that she only partially recognized the symbolic dimension of her relation with the patient. In the second case presentation, the actual ‘change’ or the effect on the presenter’s subjective position is more clearly articulated. Here, the presenter’s shift from irritation to compassion seem to stir the initial images of the situation. Whereas, before the discussion, the presenter seemed to understand her difficulty in a rather one-dimensional way, the confrontation with her ambivalent stance disrupted this image. Exploring the right balance between confronting participants with unexplored perspectives on the one hand and respecting their defences on the other hand was found to be present in each of the groups. Moreover, in all four groups, members continually reported having been inspired by their peers’ presentations and by the group discussions, even during the meetings in which they had not presented a case.

Although Balint groups are not meant to be therapeutic groups, Balint group work can, to a certain extent, have a therapeutic effect [11, 28]. In this context, we believe that the mere provision of “a space in which positions can be voiced and counter-positions assigned without considerations of ‘how’ realistic they are and without them being restrained by everyday rules of politeness” (2003: 547) [26] is crucial. The creation of such a reflective space is one of the elements that makes Balint group work quite unique. As formulated by Elder and Samuel (1987: 1) [29], Balint groups are expected to enable “a freeing from within a range of personal reactions, rather than an imitative addition from without.” Change is said to lay in ‘the act of saying’ [15]. Along this way, members may be surprised by what unfolds. Similar to what occurs in a psychotherapeutic context, ‘change’ may become apparent by participants’ enhanced ability to adopt a wider range of discourses on the same theme, hold more complex views, and accept the perspectives of others [25]. In Balint group meetings, the aim is not to find the ‘true’ or ‘correct’ image of a situation (as such an image does not exist), nor is it to search for concrete ‘solutions’, but rather to open up the range of perspectives from which the situation can be viewed. Doing so might unlock blocked situations.
There are limitations to the present study. Because of our intention to analyze sessions on a detailed level, we were restricted to discussing only two cases. Nevertheless, examining more case presentations or studying group members’ change in discourse over several consecutive sessions (or even over several years of participation) could facilitate further understanding of the type of change members go through. Finally, while non-verbal group dynamics may also play a role in Balint group work, in this study we focused mainly on language, i.e. the presenter’s discourse and verbal group interactions. Indeed, in Lacan’s theory, verbal material comprises the essential structure around which meaning is constituted [30].

CONCLUSION

For this study, we started from the observation that GP’s subjectivity plays an important role in their everyday work. By describing the difficulties GPs presented in Balint groups and the related (subjective) issues that were illuminated, we illustrated the way subjectivity can be present in their practice. Moreover, we threw light on the type of change Balint group participation allows for and on the way this is achieved. Hence, this study pointed out the potential usefulness of Balint group work with regard to GPs’ subjectivity as well as the possible benefit to the doctor-patient relationship.
REFERENCES


In this chapter, we investigate the process of Balint group meetings by making use of Lacan’s theory of the four discourses. To this end, five BG case presentations and their subsequent group discussion were studied. Five crucial aspects of BG work are discerned. First, the puzzlement BG participants brought to the group is characterized as a confrontation with the structural impossibility that is inherent to Lacan’s discourses (1). As for the group discussion, we emphasize ‘hysterisation’ as a crucial aim of Balint group work (2), the supporting role of the discourse of the analyst (3) and the centrality of discourse interactions (4). Finally, the potential transformation of the initial puzzlement is discussed (5). We conclude by putting forth the uniqueness of the functioning of Balint groups as well as the potential usefulness of our analysis as a framework for BG leaders and professionals in charge of continuing medical education.

¹This chapter is based on Van Roy, K., Marché-Paillé, A. Geerardyn, F. & Vanheule, S. Reading Balint group work through Lacan’s theory of the four discourses. Manuscript submitted for publication.
INTRODUCTION

Over the last decades, the importance of the doctor-patient relationship has been more and more acknowledged, especially in general practice (Bower et al., 2001; May et al., 2004). In this relationship and more broadly in many aspects of their everyday work, physicians’ subjectivity is implied (Novack et al., 1997). Physicians’ subjectivity is tangible through their perceptions, experiences and expectations that shape their perspectives of interactions with patients and of medical practice in general. The way in which general practitioners (GPs) make sense of their practice can be associated with experiences of particular difficulties (Van Roy et al., 2012). However, everyday practice frequently leaves little time for GPs to explore the doctor-patient relationship and the way in which they are subjectively implied. Therefore, some authors (e.g. Arnaud and Vanheule, 2007) recommend creating a space in the professional context, where people can express elements of their subjectivity. Balint groups (BG) can provide such space, by offering participants a platform to explore subjective issues related to their professional work with patients (Balint, 1964). The present study aims to examine how subjectivity is received in Balint groups and what possible effects this might have.

Balint groups were first set up in the Tavistock Clinic in London during the 1950s by the psychoanalyst Michael Balint (1896-1970). The aim was ‘to study psychological implications in general medical practice’ (Balint, 1955). Later, Balint groups spread worldwide, albeit on a limited scale (Salinsky, 2002). Often participants are GPs, but sometimes groups also welcome other professionals in the (para)medical field. Typically, BGs comprise six to twelve members and one or two leaders; meetings usually take place on a weekly to monthly basis over several years. Participants are invited to spontaneously present cases in which the relation with a patient puzzles them (Balint, 1964). Usually one or two cases are discussed per meeting; meetings last between one to two and a half hours. After each case presentation, a group discussion focuses on the thoughts, emotions and the subjective reactions that a presented case evokes in each participant. This way of in-depth working may

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2 Mostly, groups are led by one or two leaders, also referred to as ‘facilitators’. Balint group leaders have a medical, psychological and/or psychoanalytical background. In some countries, formal leader-training programs have been established. The leaders’ task mainly consists in keeping the focus of the discussion on the doctor-patient relationship and watching over the safety of the group members.
facilitate alternative viewpoints that redefine the initial difficulties in relation to patients (Lustig, 2006).

Descriptions of Balint group principles and occasionally of group sessions can be found. However, investigations of the way Balint groups function and of the processes at work are scarce. Since process research mainly points out diverse factors, more comprehensive and explicitly theoretically driven studies are needed. The present study qualitatively investigates the process of BG work by making use of Jacques Lacan’s theory of the four discourses. As we will expand further on, these discourses define different types of social bonds that are rooted in language. Given the primacy of the social bond in the doctor-patient relationship, it is of no surprise that difficulties or challenges with regard to this social bond often arise. Difficulties in the doctor-patient relationship are precisely what Balint groups address by means of verbal exchanges in the group. This indicates that social bonds and language are central in BG work. For these reasons, Lacan’s theory of the four discourses may be a useful framework. More specifically, in this paper we study the kinds of difficulties participants bring to BG meetings and examine the way these are discussed.

Lacan’s theory of the four discourses

Building on Freud’s foundations of psychoanalysis, the French psychoanalyst Jacques Lacan (1901-1981) developed several theoretical schemes and formalizations in his seminars, which were held from the 1950s up to the 1970s. Among these, we can find his theory of the four discourses, introduced during Seminar XVII ‘L’envers de la psychanalyse’ (Lacan, 1991)3, and further developed in the next Seminar XVIII ‘D’un discours qui ne serait pas du semblant’ (Lacan, 2007a), the text ‘Radiophonie’ (1970) and Seminar XX ‘Encore’ (Lacan, 1975)4. For his theory of the four discourses, Lacan was inspired by the seminal work of the grounding fathers of structural linguistics such as Ferdinand de Saussure (1857-1923) and Roman Jacobson (1896-1982). Just as in many of his other schemes and formalizations, Lacan makes use of algebraic symbols to explain the functioning of the four discourses he discerned. This type of far-reaching abstraction is typical for Lacan’s work. By using formal

3 An English translation of this seminar is available and is titled ‘The Other Side of Psychoanalysis’ (Lacan, 2007).
4 An English translation of this seminar is available and is titled ‘Encore, On Feminine Sexuality: The Limits of Love and Knowledge’ (Lacan, 1998).
structures, he attempted to avoid fixed meanings and one-sided interpretations (Vanheule, 2011). This, however, also implies that understanding these mathematically presented structures is a rather arduous exercise.

Lacan’s theory of the discourses is a formal system that outlines types of fundamental relationships or social bonds. According to Lacan, social bonds are rooted in language (Lacan, 1975). A child’s acquisition of language or, as Lacan puts it, the introduction to the Symbolic, coincides with the loss of a mental state of totality. Henceforth, the child creates representations of reality, as a result of which absence and lack too obtain a mental status. For example, a dissatisfied child can image states of gratification and addresses the other through language, but neither the representation nor the other’s response can ever fully solve the dissatisfaction upon which the appeal is based. In Lacan’s view, the experience of subjective lack is crucial to human beings: lack engenders subjectivity and marks all later experiences in life. Nonetheless, different modes of dealing with subjective lack can be discerned. In his theory of the four discourses, Lacan outlines four ways for the ‘divided subject’ to deal with the human condition of lack, which results in different kinds of social bond.

Principally, Lacan’s discourse formulae consist of four terms and four positions. The four terms can rotate – in a fixed order – over all four positions, resulting in four different discourses. The four positions (see Figure 1) are defined as agent, other, product and truth. In each of the discourses, the agent (in the upper left-hand corner) addresses the other (in the upper right-hand position) in a relationship that corresponds to the manifest expression of a speech act. The agent is not to be seen exclusively as a concrete person, but can also be apprehended for instance as an ideology or tradition (Neill, 2013). However, this agent is only the apparent agent of the discourse: the operation at the upper level is driven by what Lacan calls the truth (in the lower left-hand corner). This truth is unknown to the agent and moreover, cannot be completely known or verbalized as ‘it is only accessible through a half-saying [mi-dire]’, and ‘cannot be said completely, for the reason that beyond this half there is nothing to say’ (Lacan, 2007b: 51). Therefore, this process results (in the lower right-hand position) in a product, which always implies the creation of an irreducible rest or loss, as that which escapes the discourse.
Besides the four positions, the formal structure of each discourse contains two disjunctions. At the upper level of the discourse there is a disjunction of impossibility (represented by a one-way horizontal arrow ‘\(\rightarrow\)’), which is closely linked to the disjunction of the impotence at the lower level (represented by a double bar ‘\(/\)’). The upper disjunction, that of impossibility, indicates that all human relations are marked by an impossibility, which leads to discontent. Harmonious communication and connections do not exist: the agent is driven by a truth that cannot completely be verbalized, and in addition to this, the message an agent sends is never perceived by the other as it was intended. This disjunction of impossibility is closely connected to another disjunction, that of the impotence, at the lower level of the formula, which concerns the ‘impotent’ link between truth and product. This impotence concerns the aforementioned fundamental subjective lack, which, structurally, cannot be undone. In the hope of overcoming this lack, the subject addresses the other, but this attempt always fails somehow.

Across the four discourses, the positions and the disjunctions remain the same. However, the positions are each time occupied by different terms, which rotate over the discourses. The **four terms** (\(S\), \(S\)'s, \(S\)'s and \(a\)) are key concepts in Lacan’s work. Two of the terms, \(S\) and \(S\)', are ‘signifiers’. Put briefly, signifiers are the material elements of which language is constituted. Typically, they are words or fragments of words by means of which we build sentences and narratives. \(S\)'s, or the master signifier, is any signifier that dominates a discourse and gives it sense; it is a term, phrase or concept that dominates a discourse without it being questioned. For example, in contemporary medicine, ‘evidence’ is a master signifier, just as in religion, ‘God’ is a master signifier. \(S\) represents the body of signifiers by means of which knowledge or messages are communicated. Characteristically, knowledge...
and messages are constructed around master signifiers, which is why across the four discourses, $S_1$ always precedes $S_2$. The other two terms are both an effect of the signifier. The third term is $S$, the divided subject, barred due to the aforementioned subjective lack that resulted from the introduction of language. Via language we connote who we are and what we live through, but it remains impossible ‘to say it all’. The fourth term ($a$) stands for the ‘object $a’$, referring to what is left behind by the introduction of the Symbolic (Lacan, 1973, 2004). As we use language to express ourselves, there is always an unsaid remainder. The barred (or divided) subject is driven by this remainder, but it can never be attained, which is why across the four discourses, ($a$) always precedes $S$.

The rotation of the four terms in a fixed sequence over the four positions results in four discourses. The four discourses concern four modes of relating to the other, or four types of social bond, each allowing for certain effects, but at the same time hindering others (Fink, 1995). Therefore, discourses may have an impact that is experienced as agreeable, but all contain their disjunctions as well, which make them disagreeable at the same time. We now briefly present the four discourses. Starting from the discourse of the master, the other three discourses ensue by rotating each term one counterclockwise quarter turn. Moreover, we provide an example from a medical context for each of the discourses.

**Discourse of the master**

\[
\begin{align*}
S_1 & \rightarrow S_2 \\
S & \rightarrow a
\end{align*}
\]

**Figure 2.** Lacan’s representation of the discourse of the master

In the discourse of the master (see Figure 2), the master signifier is in the position of agent and addresses the other who is in the possession of a certain kind of knowledge. This discourse represents power and mastery: the ‘master’ must be obeyed simply because he or she says so (Fink, 1995). As referred to before, this ‘master’ does not necessarily refer to a personified authority, it can also be understood as an ideology, ‘a socially identified ruler or
the psychic mastery of each and every individual’ (Nobus, 2000). In the discourse of the master, a straightforward idea is accepted as self-evident. At the manifest level, the master appears as a solid rock, undivided. Qua straightforward idea $S_i$ generates a sequence of signifiers and ideas, which constitute knowledge ($S_i$) and which are organized around what we accept as self-evident. However, the hidden truth or driving force behind this discourse is that the master signifier is not self-evident, and only based on subjective preference and belief ($S$). Therefore, in the formula, the divided subject makes up the truth of $S_i$. Moreover, the master discourse is marked by an inherent impossibility: everything cannot be contained in signifiers. It results in an ever-increasing production of surrogates of the object $a$, the lost object, that are not capable of reducing the subjective lack. In other words: ‘no matter how hard a master tries to govern and control knowledge ($S_i$), the latter will always partially escape’ (Nobus, 2000).

In the context of a medical consultation, this discourse could be exemplified by a physician expressing a diagnostic judgement (e.g. ‘you have measles’) or medical advice (‘you should stop smoking’) to a patient, the diagnosis or advice being the $S_i$. In a way, the master discourse reduces the patient to ‘a medical object’ (i.e., a diagnostic label or someone who should subscribe to well-intended advice), while at the same time neglecting the truth that the doctor him-or herself is divided as well. Nonetheless, a doctor in his or her professional role is – to a certain degree – expected to use the discourse of the master: he/she is supposed to make diagnoses, to intervene and to take position at crucial moments, and not let his or her subjectivity prevail. It is only a rigid use of this discourse that might become problematic.

**Discourse of the university**

$$S_i \rightarrow a$$

$$S_i \ // \ S$$

**Figure 3.** Lacan’s representation of the discourse of the university
In the discourse of the university (see Figure 3), constituted knowledge is in the commanding position, approaching the other as an object to whom this knowledge can be applied (Verhaeghe, 2004). The hidden truth is that knowledge rests on ideas that are accepted as a self-evident doxa: a master signifier underpins all knowledge. Principally, the discourse of the university is tantamount to rationalization and the transmission of already established knowledge. However, if the other is treated as an exemplar of the agent’s knowledge, divided subjectivity will be excluded and therefore produced: knowledge cannot exactly denote the other. Between the S that is thus produced and the S, that is used as a reference on the basis of which knowledge essentially builds, no correspondence at all can be found.

In the context of a medical consultation this discourse is at work, for instance, when a doctor provides statistics and scientific information (S,) indicating how harmful smoking is to one’s health (S.). This knowledge is communicated to the patient who is essentially reduced to an object or, more precisely, just another example of a smoker (a), to which specific knowledge is applicable. This type of approach, however, rules out the patient as a (divided) subject with respect to his or her specific relationship to smoking (S). Similar to our comment about the discourse of the master, the discourse of the university constitutes a necessary part of a doctor’s job (e.g. in the form of sharing and providing information to patients). Similarly, it becomes potentially problematic if the doctor’s discourse is reduced to that of the university.

**Discourse of the analyst**

\[
\text{a} \rightarrow \text{S} \\
\text{S,} // \text{S,}
\]

*Figure 4. Lacan’s representation of the discourse of the analyst*
A subsequent counterclockwise turn produces the discourse of the analyst (see Figure 4), as the inverse of the discourse of the master (i.e. all terms in one discourse are situated at the opposite place in the other). What is at the hidden level in the discourse of the master is manifest in the discourse of the analyst and vice versa. This discourse refers to the position a psychoanalyst typically occupies: she/he asks for free association and invites the other to grasp something of that what has not been said, i.e. object a. Along this way the subjective division of the other is brought to the fore. In this discourse, knowledge is situated at the place of the truth: the analyst is informed by knowledge about psychoanalysis and psychopathology, and precisely because of this, she/he hangs on to occupying the position of the (a). Knowledge motivates the process but is not transmitted nor made explicit, in other words, it is kept under the bar. In this discourse, the subject that is addressed produces new master signifiers, i.e. crucial ideas and insights on who she/he is, and on what she/he is marked by.

Although this type of interaction is probably rather rare in the context of a (classical) medical consultation, some GPs occasionally engage in the discourse of the analyst. For example, when the doctor attentively listens to the patient’s narrative and puts the patient’s division to the fore, the discourse of the analyst is at work.

**Discourse of the hysteric**

\[
\begin{align*}
S &\rightarrow S_1 \\
\alpha &\parallel S_2
\end{align*}
\]

**Figure 5.** Lacan’s representation of the discourse of the hysteric

In the discourse of the hysteric (see Figure 5), the agent addresses his/her subjective division to a (presumed) master at the place of the other; the latter is supposed to know and to produce an answer. This movement generates (new) knowledge (S_1). Given the fact that this discourse is the only one that produces knowledge, it was also referred to as the genuine discourse of science (Lacan, 2001a, 2001b), i.e., the discourse that leads to innovation. However, the knowledge that is produced will always be somehow beside the
point, ‘unable to produce a particular answer about the particular driving force of the object a at the place of the truth’ (Verhaeghe, 1999).

In a medical consultation context, this discourse often takes an important place, generally with the patient in the agent position. Pain, suffering, illness is what brings patients to the consultation office, hoping to find an answer in the doctor’s diagnostics and treatment proposals. Usually, in a consultation context, physicians rarely engage in the agent position of the hysteric discourse; however, occasionally they may reveal their doubts or complain to the patient about what they are suffering from: long working hours, demanding patients, personal problems, etc.

**Discourse interactions**

Above all, Lacan’s discourses outline dynamics or fields of tension. This not only goes for each of the discourses separately, but also for the interaction between the discourses. Indeed, to the previously described inherent logic of each of the discourses, we can add the articulation between different discourses.

From the previously provided examples, it became clear that each of the discourses can be found throughout medical practice. Nevertheless, we noted that in their professional role, doctors will predominantly engage in the discourse of the master and the discourse of the university. In both discourses, the divided subject is situated at the latent (i.e. lower) level, at the positions of hidden truth and product/loss. These two ‘universalizing’ discourses find their counterparts in the other two discourses where ‘particularity’ is put on the foreground. As already pointed out, the discourse of the master is the reverse of the discourse of the analyst and vice versa; likewise, the discourse of the university is the reverse of the discourse of the hysteric. As noted above, none of the discourses are problematic per se, but holding fast to one discourse can be; the persistence of one discourse provokes the disjunctions to play a more prominent and therefore hampering role. Due to their impossibility and impotence, discourses always fail (Lacan, 2001a); the circle is not complete (Neill, 2013). However, these failures allow a dynamic of transition between discourses and thus between social bonds (Lacan, 2001a). Due to these disjunctions, discourses keep on being produced (i.e. endless attempts to say it all) and social bonds are maintained or pluralized.
METHODS

Data

For this qualitative study, five audio-taped Balint group meetings were analyzed in depth. These tapes were part of a larger sample of audio-taped meetings that were gathered through a one-year-long non-participant observation of four Balint groups. Three of these groups were Belgian (French-speaking) and one was Dutch. The first author attended all sessions as a non-participant observer. Given the fact that one researcher in this study was not familiar with the Dutch language, the Dutch-speaking Balint group was not taken into account in this study. All Balint groups had 8 to 9 participants and 2 leaders, and held monthly meetings for approximately 2.5 hours. In these meetings two cases (lasting approximately one hour each) were successively presented and discussed. Although two of the three groups included were mixed (including, for instance, GPs, physiotherapists and nurses), we deliberately chose cases that were presented by GPs, as this was the focus of our research.

Data-analysis

All four authors, having a background in Lacanian psychoanalysis, read and reflected on each of the transcriptions both individually and jointly. After the individual analysis of a case, different points of view were discussed jointly. Starting from the question ‘how a Balint group works’, we gradually developed a representation of Balint group work making use of Lacan’s theory of the four discourses. Rather than strictly applying the discourses to our data, we used them as instruments that shed light on the dynamics observed in the Balint sessions. By exploring the position from which statements were made, both at an apparent and a more hidden level, by trying to delineate the other that is addressed and by examining the effect that is produced, the function of the four discourses in Balint groups became more obvious. Moreover, by identifying the turning points in the transcripts, the dynamics between the discourses emerged.

Throughout the discussions, our ideas about Balint group work were further constructed, adjusted and refined. After having analyzed five cases, all authors agreed that saturation was
reached. For the presentation of the results, we focus on five crucial components of Balint group work. First, there is the participants’ initial puzzlement that they bring to the group, which we understood in terms of a confrontation with the discourse disjunctions (1). Subsequently, we discerned ‘hysterisation’ as the central aim of Balint group work (2), the discourse of the analyst as the driving force of the group process (3), and the role of discourse interactions in relation to the discourse disjunctions (4). Finally, we examine the potential transformation of the initial puzzlement (5). The above components are illustrated with examples from our data.

**FINDINGS**

**Puzzlement: disjunctions in the discourses**

In all Balint group meetings the proceedings were similar. After settling down, practical information is exchanged and follow-up reports from the presenters of the previous session are solicited. Subsequently, one of the animators invites the group members ‘to present a situation’. After a brief or sometimes a longer silence, one group member begins to describe a situation related to the work with a patient, without the use of notes.

We observed that during BG meetings GPs always tend to report situations that puzzled them. This so-called puzzlement has three characteristic facets: the GP was affected by a clinical situation, failed to understand the situation, and did not know what to do or how to proceed. In Case 1, for example, the puzzlement the GP brought to the group regarded a patient who had expressed dissatisfaction with the GP’s unresponsiveness in relation to his first grandson’s birth announcement card. The patient had been concerned that the GP had not received the card and had remarked that he understood his mother stating: ‘the more I know people, the more I like dogs.’ The GP stated that he had experienced ‘indefinable malaise’ and ‘a blank mind’ in relation to the patient’s comment, and that following this statement he had not known ‘how to escape’. Apparently, the GP had been affected by the patient’s comments, which left him speechless for a while. In Case 2, the GP described feeling stuck in relation to a violent man that he had accepted as his patient again. Two main difficulties were put forward, which bore witness to his failure to adequately address the
other. First the GP mentioned the fear and uneasiness that the patient’s physically aggressive behavior had evoked in him. He explicitly stated that he mistrusted the potential blinding effects a situation of fear could elicit, both in himself and in the patient. Next, the GP also mentioned the ‘loyalty conflict’ that this situation created, since he was also the GP of the patient’s girlfriend. In Case 3, the GP reported a telephone call by a desperate mother who did not know what to do with her thirty-year-old son, who was a patient of this GP. In the experience of the GP, this mother expected a clear answer and advice, thus putting the GP in the position of master. However, this had embarrassed the GP in question, failing to adequately deal with the request.

In each of our cases, the GP felt being put in an emotionally affecting position, and did not know how to respond to the patient: the GP was blocked in the social bond. In terms of Lacan’s discourses, he/she was confronted with the disjunction of impossibility. The GP failed to make sense of the distressing event, and qua agent he/she couldn’t adequately respond to the other who was consulting him/her. The experience of failure stands to the fore. However, in daily practice GPs are supposed to ‘keep the machine turning’ and to remain professional, which is why usually such puzzlement is not further explored. Balint groups, by contrast, offer a platform for elaborating experiences of professional difficulty.

**Hysterisation as the central aim in Balint group work**

In the discourse of the hysteric (see Figure 5), the divided subject (S) addresses the other with the aim of obtaining a master signifier (S,) that will make sense of the puzzlement one is confronted with. Applied to the Balint group, this first of all means that by recognizing and acknowledging his/her own puzzlement the GP assumes the position of divided subject, or starts a process of ‘hysterisation’ (Fink, 1995; Miller, 1988). This implies that the presenter does not merely blame the other, but feels divided: he/she reacted in a certain way, and assumes his/her responsibility for not having acted differently; it entails the induction of a question about his or her own implication in the situation. Indeed, in the Balint group sessions that we studied, participants were generally willing to present cases, albeit to varying degrees. However, the extent to which their subjective division was put forth, differed among participants. Some discussed work-related difficulties with a principal focus
on the patient or the circumstances (e.g. Case 3 and 5); others reflected upon the way they themselves potentially were implicated in the situation. For instance, in Case 2, the presenter immediately put forward elements that may have contributed to why he had accepted the man to become his patient: he felt both seduced and put under pressure by the patient, and he was hoping to be able to do something for the patient’s girlfriend.

The master signifier that is supposed and addressed, and the type of knowledge that is produced, also vary. Some participants were hoping that the group would provide them with insight (e.g. Case 5: ‘I wanted to know whether you can provide me with some ideas about how I could have avoided being taken in by that inextricable situation and to have managed better’) or were hoping for solutions (e.g. in Case 3, the presenter seemed to expect ideas about how to respond to the desperate mother and her rebellious son); still others used the group as a place to reflect on their own actions and expectations (e.g. Case 2: ‘I will have to investigate this therapeutic rupture’). In Cases 3 and 5, the agent expected the answer coming from the other group members. In Case 2, the others were not so much expected to come up with a solution, but to offer a platform for reflection, such that the presenter could find unconscious determinants of his own behavior. Indeed, generally, working with the unconscious is central to BG work. For instance, similar to the requirements formulated to a patient who starts a psychoanalytic treatment, BG group participants are not expected to prepare sessions or cases, and are invited to speak freely. Moreover, some group interventions (e.g. the punctuation of slips of the tongue or of remarkable phraseology) aim at the emergence of this different type of knowledge.

The ideas or knowledge (S₁) that are actually produced along this way may signify or make sense of the presenter’s dividedness. In that case they are acknowledged as relevant, which is represented by the arrow from S₂ to S in Figure 6. This acknowledgement implies willingness to accept viewpoints that differ from the way one was previously looking at the situation, and/or openness to accept contradictions and unconscious motives. For instance, in Case 3 the presenter often lacked such openness, and appeared to be deaf to an animator’s underscoring of a slip of the tongue. As she was talking about the 30-year-old son, the GP stated: ‘that child, well, I mean that man’ but did not react to the animator’s reference to this slip. In Case 2, by contrast, the presenter instantly recognized a
participant’s suggestion that maybe his ego was also flattered by ‘this patient’s declaration of love’.

Figure 6. The discourse of the hysteric as central to Balint group work

However, as the discourse of the hysteric is strongly focused on the signifier, the object a remains in the position of hidden truth: there is no direct exploration/interpretation of how someone’s personal style of dealing with lack determines how he/she behaves professionally. Indeed, a Balint group differs from a therapeutic group (Balint, 1964). This is guaranteed by certain group rules, such as addressing others respectfully and avoiding confrontations that are too personal, which is watched over by the animators. This also means that for a deeper elaboration on why one consistently makes the same errors or takes the same decisions, a personal therapy might be relevant. At best, BG work evokes, what Lacan (2006) called, ‘instants of the glance’\(^5\), i.e., moments where one suddenly becomes aware of something. On some occasions, it allows for deeper reflection, although an extended ‘time for comprehending’\(^6\) is not feasible in Balint group meetings.

**Discourse of the analyst: the motor of Balint group work**

Whereas stimulation of the discourse of the hysteric was found to be a central aim in BG work, we believe that the discourse of the analyst (see Figure 4) is the support or guarantee of this process. In Lacan’s view, the analyst’s main function consists of enabling the exploration of subjectivity in the discourse of the hysteric: ‘What the analyst establishes as analytic experience can be put simply—it’s the hysterization of discourse. In other words, it is the structural introduction, under artificial conditions, of the hysteric’s discourse’ (Lacan, 2007b: 33). By addressing the subject from what could be apprehended as an empty or open place in the social bond, indicated by the object a qua agent in the discourse of the analyst,

\(^5\) In French, this is referred to as ‘l’instant du regard’ (Lacan, 1966).
\(^6\) In French, this is referred to as ‘le temps pour comprendre’ (Lacan, 1966).
space is created for the divided subject to speak and to find out which master signifiers have been determining his/her actions. In the formula of the discourse of the analyst, the latter is represented by $S_\alpha$, as the product that is achieved.

Specifically, in the BG sessions, the discourse of the analyst was found to be adopted by both the animators and group members. For instance, pointing at ruptures in the story or underscoring remarkable expressions frequently steered the discussion in a different direction. Examples were found in all of the sessions we analyzed. In Case 1, for instance, one animator invited the presenter to reflect on the actual meaning of the signifier ‘faire-part’, which he had been using frequently. In Case 2, for instance, one animator pushed the exploration of the reasons for taking back this patient a little further: ‘What did he [the patient] do for you to say ‘yes’ that day? Or don’t you know? How ...? What did he say?’. In Case 4, at a given moment, a participant questioned and at the same time designated the patient’s behavior as a role she is playing (‘But why does she need that?’ ‘Need what?’ ‘Well, playing that role’). With this intervention, the patient’s suffering and her dividedness were put forward, which steered the group discussion in a different direction, i.e., from the description of the patient’s irritating behavior to the exploration of the underlying dynamics.

The discourse of the analyst is also installed when the group is asked to focus on the particularity of the case, and avoid discussions in general terms. Explicitly probing the presenter’s puzzlement or reason(s) for presenting the case is another example of establishing the discourse of the analyst. If the presenter doesn’t spontaneously assume the position of the divided subject, explicit invitations for doing so were sometimes observed. For example, in Case 5 the presenter hardly formulated self-referential statements, which brought the group to repeatedly probing for her implication in the story (e.g. ‘And how are you yourself situated in this story?’; ‘What is bothering you?’). In Case 3, by contrast, the discourse of the analyst was relatively absent, which might explain why little hysterisation was observed during the discussion. Despite multiple occasions for taking up the discourse of the hysteric, this was hardly ever done, with the group adopting mainly a problem-solving focus and a diagnostic-labeling discourse, which bears witness to adopting the discourse of the university.
In this process, the animators and the group play a facilitating role. However, just like in clinical psychoanalytic work, the actual adoption of discourses largely seems to depend on how the presenter engages in speech. A potential switch in discourse requires in the first place an openness to different discourses. A non-reception of the discourse of the analyst was for instance found in Case 3. As one of the animators highlighted a slip of the tongue in the presenter’s narrative in which the GP seemed to present herself as ‘undivided’, this was neglected by the presenter, as well as by other group members, who continued to focus on factual information (i.e., ‘How long did the telephone call last?’).

**Tackling impossibility: discourse interactions**

While the close interaction between the discourse of the hysterical and the discourse of the analyst are crucial to BG sessions, these are not the only discourses at play in Balint groups. The discourse of the university (see Figure 3) was also found to be present at different levels. First, this discourse came to the fore when presenters provide factual information related to the case they present (e.g. about the patient’s history, about the circumstances of the difficulty at stake,…). Furthermore, during the group discussion, other participants often asked informative questions and proposed explanations on the presenter’s puzzlement. In both situations, exchanging knowledge and rational thinking are central. In all studied cases we clearly observed this discourse. It seems that in response to subjective division, BG members often produce all kinds of explanatory narratives. For instance in Case 1, participants provided many suggestions and ideas for explaining the patient’s behavior (e.g., ‘He might have great expectations towards the doctor,’ ‘He is living in a tense situation’). With numerous questions, participants also probed for more information (e.g. ‘How did the consultation continue?’, ‘Was there any violence as a child, with his father?’).

Interestingly, the product of the discourse of the university is subjective division. In the BG sessions we observed that focusing on knowing and knowledge at times results in the eruption of the subjective division, breaking up the chain of knowledge. Rational explanation may be experienced as insufficient, which is why openness for exploring incoherencies in subjective experience comes to the fore. If this dividedness is acknowledged, a switch to the
discourse of the hysteric might take place. As indicated previously, this might be facilitated by the discourse of the analyst (see Figure 7).

For example, in Case 2, as participants discussed factual information about the situation presented (e.g. the chronology of the events, legal concerns, etc.), one member suddenly gave voice to her confusion: ‘I am confused, because I remember you already spoke about this girl (...) Well, it looked like the relationship between the patient and your colleague was going well. And so, it is really surprising that x time later, well, it has completely changed, all rules are different (...) I don’t understand what could have happened to you so that you accepted to take him back’. The presenter took this remark as an invitation to reflect on the apparent ambiguities in what he had said, and started addressing factors that may have been motivating him.

The discourse of the master, on the contrary, was rarely observed in the Balint sessions. This is mainly to be ascribed to the Balint group rules and principles themselves: a Balint group is a group of peers (in which any form of hierarchy is avoided) where animators are to watch over the process, but never to act as experts or supervisors (Oppenheim Gluckman, 2006). Moreover, instructing the other as to how to proceed or to understand a situation is never the purpose of BG work (Lustig, 2006). Nevertheless, occasional engagements in the discourse of the master could be observed, for instance, in Case 1. When a participant evoked ‘universally applicable rules’ as a ground for steering one’s actions (‘I think that with regard to “etiquette”, we are not obliged to answer [patients’] wishes and announcements, be they related to marriage, birth or whatever... That’s a certainty, we are dispensed from it’), two other participants reminded this BG member to restrain from being conclusive (‘You are speaking for yourself, because you’re using a majestic plural, but you’re speaking for yourself’ and ‘But I think that everyone has one’s own way of reacting’).
Switching between discourses is of utmost importance. If it fails to happen, and the group sticks, for instance, to the discourse of the university, the Balint group starts to function as a problem-solving group that focuses on answers and solutions and that leaves out the exploration of subjectivity. The same goes for the discourse of the hysteric. While the discourse of the hysteric is central in BG work, a too strong focus on this discourse might reduce a BG to a support group where peers share complaints and concerns. The potential power of BG work lies in the multiplicity of discourses at work and in the possible interaction between different discourses.

It is important to remember that the disjunction of impossibility is both what makes the discourses fail, and what allows the switch between discourses. As mentioned before, these switches seem to be part of the core of BG work. Switching between discourses tackles the initial puzzlement by moving the impossibility experienced in one discourse to a different place in another discourse, which results in reframing the puzzlement. Several elements were found to contribute to this dynamic. First, the overall structure of BG discussions stimulates different types of reactions. Generally, after the case presentation, participants ask the presenter clarifying, information-generating questions. This implies engagement in the discourse of the university, where knowledge and understanding are central. Subsequently, once basic information on the case has been shared, the group usually engages in a more free associative circulation of ideas and fantasies, which bears witness to engagement in the discourse of the hysteric. Apart from this generally observed structure, discussions are often not linear: there is no aim of reaching a final synthetic conclusion, and there is always the possibility of returning to previously expressed ideas, utterances or suggestions. For instance, in Case 5, one animator came back after some time to remarkable words the presenter had been using: the patient had ‘dismissed’ her and she was ‘convoked’ by the patient. While these words remained unnoticed at first, underscoring them invited the presenting GP to further explore the way she experienced the relationship with the patient. Finally, participants also literally switch positions across different sessions: sometimes they present a case; more often they merely react on cases presented by someone else.
The end of the session: the potential transformation of the initial puzzlement

Most sessions end without a conclusion or solution, nor with a ‘correct’ way to see the case, which is in line with what Balint (1964) intended. Considered from Lacan’s theory of the discourses, this might indicate that the group acknowledges the disjunction of impotence, which separates (the position of) the truth from (the position of) the product and which is inherent to each of the discourses. However, switching between discourses might be a way of dealing with this impotence. At best, switches between discourses in BG sessions produce bits and pieces that can be useful to the presenter: different points of view on a case, ideas on how one might react differently, a feeling of relief around issues one experienced as problematic,... Where the universalizing discourses (the discourse of the master and the discourse of the university) are often dominant in medical practice, their more particularizing counterparts (the discourse of the analyst and the discourse of the hysteric respectively) can unfold in Balint group meetings.

Indeed, following the presenters’ initial puzzlement, a change in the three facets of puzzlement (i.e. failing to understand, failing to act and being affected by the situation) might be produced. For instance, in Case 1, the presenter’s initial ‘indefinable malaise’ was reframed as ‘culpability’. Some of the elements that possibly determined the patient’s expression were clarified, and aspects of the presenter’s own implication became apparent as well. BG discussion might also affect the presenter’s preparedness to act, as is apparent in Case 2: whereas at the beginning of the session the presenter wondered how to get rid of the patient without too much violence, he stated near the end of the session ‘having more elements that make him want to keep the patient’. Frequently, a clearly notable affective relief was noticed, which can be ascribed to the symbolization of affects. This was for instance very apparent in Case 4. While at first, the presenter’s frustration about the situation and the patient came to the fore, the affective relief near the end of the session was clearly perceptible. Eventually, the work during the BG session might help the presenter to take up the discourse of the master again – whenever necessary in clinical practice – with the GP being at ease in his professional role.
DISCUSSION

Analyzing five Balint group sessions through the framework of Lacan’s theory of the four discourses enabled us to shed light on the process of BG work from a particular theoretical angle. While a confrontation with the disjunction of impossibility was often found as the ground for presenting a case in a BG, the focus on hysterisation and the interaction between discourses appeared to shape the group discussions. This interaction might result in creating bits and pieces of new knowledge, focused on particularities of the case. A BG might be apprehended as a transitional space where elements that don’t fit the habitual work-related discourse can be received and explored in order to take up everyday clinical work again. As the discourse of the university and the discourse of the master often dominate GPs’ everyday practice, a BG might provide a dispositive where that which is usually kept under the bar (i.e. the divided subject) can be explored. The focus on the work with subjective division appeared to be crucial in BG work. GPs are not only scientifically trained professionals with extensive knowledge on medical issues, technical expertise, and clinical skills, they are also human beings who are affected by their work and who can sometimes be surprised by how they act or, in relation to some patients, experience difficulties in acting in a way they deem appropriate. Specific BG procedures, like the absence of case preparation and the incitation of free associative speech, seem to stimulate access to their subjective dividedness. Acknowledging the unconscious, in the dynamic psychoanalytic sense of the word, is one of the features that clearly distinguishes Balint group work from other types of continued medical education.

In order to allow for this process, a special and often difficult task is assigned to the animators. On the one hand, animators have to install a structure where subjective division is recognized and challenged, i.e., where participants are invited to talk about their own subjective division and to engage in the discourse of the hysteric. On the other hand, they need to protect participants from ‘wild interpretations’ by other members and to watch over the safety of the group. They balance between challenging group members to transcend their established way of thinking on the one hand, and helping them to respect each other’s personal style. Therefore, we believe that Lacan’s discourse theory, and more specifically his focus on discourse disjunctions and discourse interactions might offer animators a framework for reflecting on the process of BG work.
We already pointed at certain resemblances between BG work and individual psychoanalytic treatment. Despite a very different context (i.e. group versus individual work), similar working principles apply to both. Putting the divided subject to the fore and supporting this by means of the discourse of the analyst, for instance, are central in both. Next to this, the ability to switch between discourses was also brought up against pathological ways of functioning in the context of individual analytic treatment (Quackelbeen et al., 1994). However, we also emphasized that BGs are not to be considered therapeutic groups. We stressed that, for instance, there is no exploration in the group of deeply personal issues (Balint, 1967), nor can there be a process of extensive working through. Moreover, meetings often take place only once per month; and given the fact that presenting time should be distributed among the participants, the opportunity to present cases is limited. On the contrary, listening to cases presented by colleagues, trying to understand and questioning other members’ narratives, being confronted with sometimes very different stand points are all factors that in our opinion contribute to the possible achievements in Balint groups, i.e., being more sensitive and flexible in the work with patients (Balint, 1964). Moreover, by addressing their own subjectivity, BG participants can start to be more sensitive to the patient’s dividedness. Indeed, we observed that as a result of having discussed a case, presenters had more complex ideas about their patient. However, this is an issue that needs to be studied more closely.

A few authors have provided new insights in some work-related topics such as organizational dynamics (e.g. Arnaud, 2002) and burnout (e.g. Vanheule et al., 2003; Vanheule and Verhaeghe, 2003) by adopting a Lacanian perspective. Using Lacan’s discourse theory to interpret empirical data appears to be rarely used (e.g. Chung, 2007). In our opinion, using this framework in the present study appears to have been fruitful and could possibly be applied to other contexts. The findings of the present study molded our understanding of the process of Balint group work and pointed out its specificity. We argue that elements of this study may guide BG leaders in their work and inform professionals responsible for organizing (continuing) medical education about the specificity of Balint group work.
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In this final chapter, we briefly summarize the findings presented in the previous chapters and provide a critical discussion of our study as whole. We start by discussing the connection between the findings of our first study (interviews with GPs) and the Balint group observations. Subsequently, we provide some critical reflections about Balint groups: we go deeper both into the specificity of Balint groups and the limitations of Balint group work. Methodological issues with regard to our studies are discussed and practical implications are considered. Finally, we hold still to the study limitations and we suggest pathways for future research.
In this dissertation, we aimed at investigating the doctor’s side of the doctor-patient relationship, as we indicated in Chapter 1 that this perspective has been given too little attention in scientific research. More specifically, we aimed at gaining insight into the way general practitioners make sense of their practice and into the difficulties they may experience in their everyday consultations. This was the main objective of our first study (Chapter 2). In the subsequent studies, we examined the potential value of Balint groups for dealing with difficulties related to the work with patients. We first carried out a systematic literature review on the existing research of Balint groups (Chapter 3). Then, we performed two qualitative studies of Balint groups, based on the observation of the meetings of four Balint groups for more than one year. Lacanian theory was the theoretical framework that guided both studies. In Chapter 4 we presented an in-depth study of two cases, describing in detail the evolution of a difficulty presented at a Balint group meeting. In a second study (Chapter 5), we aimed at typifying Balint group processes and interactions by analysing five BG sessions starting from Lacan’s theory of the four discourses.

SUMMARY OF THE MAIN FINDINGS

In Chapter 2, we explored GPs’ narratives about their everyday practice by inviting them to speak about ‘good’ and ‘bad’ consultations. We discovered predominant themes, problems the GPs prefer to deal with and characteristic difficulties they are confronted with. Analyzing these narratives resulted in the identification of four main discourses: a biomedically-centered discourse, a communication-focused discourse, a problem-solving discourse and a satisfaction-oriented discourse. Each participating GP appeared to use a subtle mix of elements from different discourses. This clearly illustrates that – in spite of relatively similar training and working conditions – GPs do not perceive clinical practice in a uniform way. Although certain elements appear to originate from the broader ‘medical discourse’ (i.e. they belong to a shared discourse among physicians), the predominant presence of specific elements as well as the presence of more personal components (e.g. the need to satisfy the patient or to solve problems) clearly traverse these perspectives and experiences. We also remarked that most participants used certain discourses more predominantly than others; this implied that they were predominantly confronted with
those difficulties associated with their preferred discourses. By highlighting the limitations
that are inherent to each of the discourses, we shed a different light on difficulties GPs
encounter in their daily practice. Clinging to a specific discourse might indeed result in
repeatedly being confronted with the same type of difficulties.

In Chapter 3, we investigated the existing scientific literature on Balint groups by means of a
literature review. 35 empirical and 59 non-empirical studies were found. Given the fact that
Balint group related research topics are very diverse and that the methodological strength of
the articles was often rather weak, no general conclusions could be drawn. Nevertheless, we
identified a number of broad research topics that were repeatedly addressed. These include
diverse outcome variables (e.g. psychosocial self-efficacy, burnout, various attitudes,...), BG
participants’ characteristics, BG themes and processes, leadership issues, BG evaluations and
attendance. As no such systematic review existed yet, this review study provides future BG
researchers with a broad overview and bibliography on Balint group research as well as with
a guide on specific research topics. Despite the shortcomings of some studies investigating
Balint groups, we found indications of the value BGs may still have today. This became
evident from a number of perspectives, ranging from qualitative studies on BG effects and
participants’ evaluations to personal reports and reflective articles. Moreover, the review
reported critical reflections that can be used as a starting point for further research and
pointed to several topics that require further research scrutiny, such as studies of ‘modified
Balint groups’ or good leadership.

In Chapter 4, we performed an in-depth analysis of two cases that were presented and
discussed in the Balint groups that we observed. By making use of Lacan’s distinction
between imaginary and symbolic relating, we interpreted both participants’ process of
change during one Balint group session. In both cases, the GPs presenting the case initially
appeared to be stuck in a fixed image of a situation, referred to as ‘imaginary relating to the
other.’ Through a range of interactions with the other group members (e.g. challenging the
presenter’s perspective, providing additional view points and inviting for reflection on
unconscious dynamics that may influence the situation), the presenters were encouraged to
explore different subject positions, which allowed them to broaden their initial image of the
situation and to discover other issues at stake. This was referred to as a more symbolic way
of relating to the other. In this way, the actual ‘change’ taking place was also found to
depend on the presenter’s capacity to take up cues for elaboration, which proved to be somewhat different in both cases.

In Chapter 5, we aimed at a broader comprehension of Balint group processes and at a further abstraction of the specificity of Balint group work. Using the framework of Lacan’s theory of the four discourses, we studied five Balint group sessions. Using this theory allowed us to understand the ‘puzzlement’ participants present in Balint groups as a feeling of being blocked in the social bond with the patient or, put differently, as a confrontation with the ‘disjunction of impossibility’. Furthermore, we perceived the aim of Balint group work as a stimulation of ‘hysterisation’, i.e., the induction of a question about the presenter’s own implication in the ‘puzzling’ situation. This process in its turn is incited and supported by the discourse of the analyst, which was found to be – at times – adopted by both the BG leaders and the other participants. Finally, we concluded that interactions between discourses are a crucial working element in Balint groups as they allow the initial impossibility to lose its fixity.

CRITICAL DISCUSSION

From discourse-related difficulties to the puzzlement explored in Balint groups

Comparing the results of the first study to our observations of the Balint groups can instruct us on the similarities and differences between consultation-related difficulties GPs spontaneously mention and the difficulties for which Balint groups offer a platform. In the first study, we investigated GPs’ narratives about their practices, more specifically by inviting them to talk about what they deem good and bad consultations. This resulted in a unique account by all participants, which bore witness to their subjective implication in the way they perceive their work. Nonetheless, we discovered some convergence between the narratives, which we typified in terms of four discourses (a biomedically-centered discourse, a communication-focused discourse, a problem-solving discourse and a satisfaction-oriented discourse). We also observed specific difficulties related to each discourse. These difficulties included: being confronted with insufficient knowledge, coping with medically ‘banal’ consultations, difficulties in making correct clinical assessments and making correct referrals,
difficulties in reading patients’ complaints accurately, stress of finding solutions, finding the right balance in advising and convincing, finding common ground with the patient, coping with dissatisfied patients, coping with lack of trust, finding the balance between the patient’s and one’s own preferences, etc. A brief comparison of these types of difficulty with the cases that were presented in the Balint groups we observed, reveals some similarities. For instance, ‘reading patients’ complaints accurately’ was a theme that often made up the core of a presentation in a Balint group. This was found in the form of questions such as ‘What is the patient telling me through his/her physical complaints?’ ‘What does the patient want from me?’ or ‘What do I mean to this patient?’. Next to this, finding a right balance or ethical stance in various matters also was a theme that frequently recurred in the Balint case presentations. This was for instance noticed in issues related to finding out where to draw the line (e.g. with regard to certifications or professional versus familiar bonds with the patient) or weighing up respect for a patient’s choice and interfering in a situation (e.g. when a patient refuses to consult or to go to hospital while the doctor thinks this is necessary). Apart from this, we also found differences between both data sets. These differences can partly be ascribed to their different points of departure, i.e. the invitation to speak about consultations in general in the interviews versus the expectation to speak about difficulties in concrete doctor-patient interactions in the Balint groups. Difficulties related to what we called the biomedically-centered discourse (e.g. lack of knowledge or the poor assessment of a clinical situation) were not often found in the Balint group presentations. This is easily understandable since the focus of Balint groups does not concern biomedical issues; nevertheless, GPs’ experiences with (biomedical) failures or doubts, or the confrontation with one’s emotions in relation to a patient’s demand were occasionally heard in the Balint meetings. On the other hand, themes less encountered in the interviews but finding a platform in Balint groups were for instance the examination of the position one is ascribed to by the patient or understanding one’s frustration about a patient. The latter themes, however, appear to us as difficulties many GPs may be confronted with one day; therefore, we don’t consider them radically different from the themes that appeared in the interviews. A possible explanation for this difference might be found in the experience BG participants have in respectively questioning explicitly the social bond with the patient and speaking openly about negative feelings with regard to patients. It might also be that the single
interview format we applied in Chapter 2 was less encouraging do disclose about such negative feelings.

Overall, we conclude that a substantial part of the difficulties we discerned in the interview narratives are similar to the themes that typified the cases presented in the Balint groups. This match indicates that Balint groups provide a place where difficulties GPs are confronted with in their daily practice can be discussed. We also conclude that Balint groups are not the place for treating mere knowledge-related difficulties (to this end, many other courses or seminars exist). Their specific value resides in examining the experience of difficulties participants are confronted with.

**Specificity of Balint groups**

In the introduction of this dissertation, we already pointed at some specificities of Balint groups. These can be supplemented with some further reflections resulting from our observations. We already underlined that Balint groups are very different from theoretical seminars; we also referred to Michael Balint’s famous expression denoting the effect of participating in his seminars as “a limited, though considerable, change in the doctor’s personality” (Balint, 1964, p. 299). In carrying out the literature review, we came across a study that quite literally tested this statement by using personality questionnaires to measure BG participants’ personality before and after two years of participation in a Balint group (Dokter, Duivenvoorden, & Verhage, 1986). No fundamental changes in personality were found, only individual changes in the perception of patients. Although we took a very different approach (i.e. qualitative research studying short-term evolution), our findings in the studies of Chapters 4 and 5 partly concur with this conclusion: over a Balint group session we often noted a change in the presenters’ perspectives of a specific difficulty with a patient. Moreover, this often resulted in a positive change in the interaction with the patient, as sometimes became apparent in the participants’ follow up reports. The idea that such shift also entails a limited change in personality cannot be corroborated by our empirical studies.
As modes of participatory, experience-based or reflective training for physicians, Balint groups do belong to a small segment of training practices for physicians, but they are not unique. However, with regard to their actual working principles, Balint groups may be thought of as different from other forms of training. Through both our analyses of Balint group work (Chapter 4 and 5), we attempted to pinpoint in what way Balint groups are different from, for instance, support, problem-solving or reflection groups. In our opinion, the difference especially lies in the specific way experiences are listened to in Balint groups.

Put briefly, this way of listening acknowledges the participants’ subjective dividedness, which is supported and stimulated by including the discourse of the analyst. In addition, the switch between different discourses was found to be a central process. By pointing at the importance of these discourse switches, we indicated in what way Balint groups differ from problem-solving groups (focusing on the discourse of the university) and support groups (focusing on the discourse of the hysteric). Indeed, although a safe and supporting environment is essential for Balint group work (Johnson, Nease, Milberg, & Addison, 2004), Balint groups are not mere support groups. Too strong a focus on support and reassurance even interferes with the goals of Balint group work (Bibace, 2004). A genuine exploration of one’s perspectives or subjective implication in a situation is likely to be accompanied by uncertainty or even anxiety. In order to allow for change, uncertainty and anxiety are to be tolerated to some degree and should not be ruled out too quickly by means of support and reassurance. In addition to this, we also argue that Balint groups are not just reflection groups. Through their explicit explorative character, by taking into account the unconscious and by recognizing the complexity and the contradictions of the human being, Balint groups not merely aim at enhanced awareness and understanding (although these are definitely part of Balint group work). Some authors (e.g. Clarke, James & Kelly, 1999) indicated the limits of reflection, for instance by stating that not everything can be reflected upon or that it is difficult for individuals to achieve a ‘deep reflection’ on their own. This statement is clearly connected to what Fink (2010) points at when he denounces a too strong focus on ‘understanding’ or ‘insight’ in psychoanalytic therapy: “Understanding may at times accompany change, but it is not a necessary prerequisite to change and may in many cases constitute an obstacle to it. Bringing things to speech with another person is what is essential” (p. 260). The idea that Balint group work is not only about understanding is supported by the observation that participants repeatedly stated in the follow up reports
that the interaction with the patient had changed, without them being able to pinpoint the reasons for this change.

Another factor we observed to be a crucial element of Balint group work, is time. Michael Balint (1954) indicated that the (personality) change he referred to, takes time. This is supported by the results of our literature review, where significant changes were only found after long-term participation (one year minimum). Moreover, Balint groups are places that offer time (which was beautifully described by a participant as “to be out of time”, referring to the opportunity to be out of the everyday working rhythm), a time to hold still to ‘small’ but fundamental things and a time for creative exploration. Michael Balint (1954) also emphasized that BG leaders should leave participants the time to make mistakes, and allow them to have their say in their own way and in their own time.

In conclusion, although Balint group work has several components in common with some other forms of professional discussion groups (e.g. sharing, reflection, and awareness), Balint groups are also places with an explicit explorative character where participants are listened to in a particular way. The combination of a challenging and respectful atmosphere characterizes the Balint groups we observed. Finally, we emphasize that Balint group participation is indeed mainly about change and not so much about learning, as was already put forward by Michael Balint (1964). To conclude, we’d like to evoke Freud’s (1953 [1905]) reference to Da Vinci’s distinction between arts that work ‘per via di porre’ (i.e., where a substance is applied, such as in painting) and those that work ‘per via di levare’ (i.e., where something is taken away, such as in sculpting), when explaining the difference between suggestion and analytic therapy. In the same way, Balint groups do not aim “to add or introduce anything new, but to take away something, to bring out something” (Freud, 1953 [1905], p. 261). Balint groups are thus not so much about learning new skills or techniques, although this can definitely be a useful side effect. Free speech about work-related problems, akin to free association in psychoanalysis, is probably what makes Balint groups work.
‘Balint discourse’ versus medical discourse

According to us, it makes sense to speak about ‘Balint discourse’ (i.e., a particular way of working that was described in Chapters 4 and 5) as opposed to a more common medical and educational discourse. This opposition partly refers to the difference between the particularizing tendencies of Balint group work to the universalizing tendencies of what we refer to as the common medical discourse. A discourse that is not didactic or solution-focused (Lustig, 2006) is not self-evident in times where efficiency, efficacy and evaluation play a prominent role. This might be one of the reasons why the idea that Balint groups are outdated is sometimes heard (Lustig, 2006). Talking about our research project, we sometimes heard the remark that other types of continuing medical education (CME) such as LOKs have incorporated the function of Balint groups. Although there may be exceptions we are not aware of, we believe that truly explorative, reflective, challenging work-related discussion in a safe atmosphere that is maintained over a long period of time is quite unique for Balint (or Balint-like) groups. Indeed, in an interview study with GPs with a history of burnout, the participants did not consider LOKs as an appropriate place for discussions about work or psychological difficulties in medical practice. Since GPs, and by extension all workers in the medical field, will always remain subjects, an approach that takes into account the dimension of subjectivity can in our opinion never be outdated.

Introducing a new kind of discourse in medicine was also what Michael Balint aimed at. Concerned about the difficult statute and organization of primary care, Michael Balint aimed to introduce a different way of apprehending medical practice. Many of his ideas concerning the dynamics in primary care grew during the first Balint seminars and were written down in his book “The doctor, his patient and the illness” (Balint, 1964). He pointed at the fact that during their training doctors learn a huge amount of ‘technical’ or strictly medical words, which is “an exact, unequivocal language, understood equally well by the consultant and the general practitioner and used by both with ease and safety” (Balint, 1964, p. 40). By contrast, words to designate for instance specific aspects of the patient’s psychological condition or the interpersonal contact with the patient are much more absent in medical

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1 LOK stands for ‘Lokaal Overleg Kwaliteitszorg’; LOKs are small, local peer-review groups for physicians.
2 This study is part of the KCE (Federaal Kenniscentrum voor de Gezondheidszorg) report on burnout among GPs (Jonckheer et al., 2011).
training. In a way, this observation of Michael Balint links up with the limitations we discerned in the discourses described in Chapter 2. We demonstrated that the scope of words available to a particular physician is closely connected to the way he/she makes sense of the everyday work and interferes with the type of difficulties he/she is confronted with. By making use of easily accessible descriptions, Michael Balint intended to pinpoint some mechanisms that may obstruct medical practice and, in this way, to offer a framework to reflect on certain dynamics. Examples of such expressions are “the patient’s offer and doctor’s response” (which refers to a process where the patient ‘offers’ different symptoms or complaints until the doctor ‘accepts’ one of them) or “the apostolic function” (which points at the fact that every doctor has – mostly inexplicitly – ideas of how a patient ought to behave when ill) (Balint, 1964).

Limitations of Balint groups

However, Balint groups also have limitations. In general, Balint groups are a minority activity – in Flanders even non-existent at the moment. During a preliminary phase of the present research project, we interviewed a number of Flemish ex-BG participants about their opinion of this absence. The most important factors mentioned were a lack of interested group leaders, financial issues, time constraints, a preference for technical knowledge and a lack of interest in questioning oneself. Practical and attitudinal obstacles thus seem to prevail. These answers correspond to a large extent with the reasons for the paucity of Balint groups in Australia as suggested by Lustig (2006) and with some of the Balint group difficulties described by Kjeldmand and Holmström (2010). Being confronted with considerable dropout rates, Michael Balint introduced the “mutual selection interview” prior to the participants’ entry in the group; in this interview, mutual expectations about the group participation were explored (Balint, Balint, Gosling, & Hildebrand, 1966). This procedure proved to be successful, but such selection appears to be hardly applied by BG leaders (Kjeldmand & Holmström, 2010). As indicated in our review study, some researchers investigated participants’ reasons for dropout or infrequent attendance and reported factors such as lack of time, discomfort or not being convinced of the relevance of Balint group work to clinical work (Musham & Brock, 1994). This corresponds with some researchers’ findings about participants’ negative experience with taking part in Balint groups, such as
experiencing the groups as anxiety provoking or the struggle to adapt to the BG process (Graham, Gask, Swift & Evans, 2009). However, it must be noted that such experiences were mainly found in mandatory groups (that are in some countries part of medical education). Creating occasions to get to know what Balint groups can offer (e.g. during medical training) might indeed be fruitful; however, the indispensability of an interest in and an openness to the exploration of subjective implication in one’s work (and all the more for doing this in a group context) might explain why obliging people to take part in Balint groups can be unsuccessful. In such case, we agree with some authors’ suggestion to adapt Balint groups to participants’ needs, especially in the case of students and residents who are often under a lot of stress with minimal opportunity to discuss this (Stein, 2003). Indeed, in order to take care of the ‘work’, people first need to take care of themselves (Stein, 2003). Without aiming to introduce a discussion on what should be called a ‘real’ Balint group, we think that we have demonstrated that Balint groups have some specific characteristics which make them quite unique places. Our study can be helpful for further reflection on ‘mandatory groups’ or ‘modified groups’.

Methodological reflections

Qualitative research

Except for the second study, all studies included in this dissertation rely on qualitative data. For the first study, we performed semi-structured interviews with 19 GPs. For the third and fourth study, we observed monthly meetings of four Balint groups over a 15-month period (April 2011 – June 2012). In total, 45 meetings (87 case discussions) were observed; from these, 33 meetings (68 case discussions) were audio-recorded. The different number of observed and audio-taped meetings is due to the fact that we conceived the first months of BG observation mainly as a preliminary phase, in which we aimed to find out if the presence of an observer would not interfere too much with the group process on the one hand and to further elaborate our research objectives on the other. In a second phase (i.e. at the beginning of a new ‘Balint year’) we introduced the question of audio-taping the sessions, to which all groups agreed. Although the presence of a non-participant observer as well as the recording of the sessions was new to the Balint groups concerned, discussions
with the group leaders assured us that these elements did not affect the group processes in a substantial way.

Finding the most appropriate data-analytical method turned out to be a difficult but at the same time inspiring undertaking. By means of reading, discussions with colleagues and co-researchers and courses in qualitative methods, we immersed ourselves in the principles of qualitative research. These principles and procedures guided us in our search to formulate answers to our research questions. After an extensive search for the ‘correct’ and most suited data-analytical method for interpreting our data, we decided to focus on describing the way we proceeded and to be as transparent as possible. We were supported in this approach by statements of experienced qualitative researchers, such as that “far from being recipes, qualitative research methods are best thought of as ways of approaching a question” (Willig, 2013, p. 177) or that “there is no single, definite way of doing IPA” (Smith & Osborn, 2003, p. 54). Moreover, by performing the literature review we became all the more convinced of the need for a decent and explicit explanation of the analytical method used, since a term alone (e.g. ‘thematic analysis’ (Parker & Leggett, 2014) or ‘immersion-crystallization method’ (Smith & Anandarajah, 2007)) does not allow for a critical judgement of the findings. For the first study, we focused on the way people make sense of their world by paying particular attention to the language they used. The analytic process consisted of three (not strictly chronological) phases. First, we clustered the ideas and expressions the participants used into broader themes. We then re-examined the narratives guided by the questions as to what the participants preferred to deal with and what kind of difficulties they were confronted with. Finally, we grouped our analyses and discovered four different discourses. For the empirical studies of Balint group processes (Chapter 4 and 5), a different stance was taken. First of all, the data consisted of observed and audio-taped Balint groups sessions in their natural context. For these studies, the heart of the analysis was not the participants’ accounts of their experiences, but the processes at work in Balint group sessions. Since such processes do not spontaneously rise up from the data, a specific frame or theory for reading and interpreting data is needed. As we already expanded in Chapter 1, Lacanian theory appeared to be a helpful framework to find out both what works in Balint groups and what possibly prevents work dynamics. In these studies, a more explicit

3 IPA stands for ‘Interpretative Phenomenological Analysis’.
interaction between data and theory was at stake. A constant back-and-forth movement between data, theory and preliminary results characterized these studies. Moreover, in the last study (Chapter 5), group discussions among the researchers were a fundamental methodological tool. Whereas in the studies of Chapter 2 and 4, discussions among the researchers served to compare and discuss individual codings and interpretations, the group meetings for the study in Chapter 5 actually served as a place where insights were gradually constructed. During the individual preparation of the sessions and especially during each of the meetings, our previously constructed ideas on Balint group processes were reconsidered, tested against a new case and subsequently adapted or refined. This method was experienced as a fruitful and inspiring way of working. These procedures were very much in line with the principles of ‘Consensual Qualitative Research’ (CQR; Hill, Thompson & Williams, 1997), which is a method that gives group discussions and the joint construction of an understanding of the data a central place.

Measures with regard to safeguarding validity and reliability mainly consisted of the aforementioned discussions among the researchers to compare and discuss codings and interpretations. Moreover, we carefully watched over constantly asking ourselves both what works and what doesn’t work in Balint groups. Finally, by engaging in a reflexive stance, i.e. reflecting with co-researchers, colleagues and people external to the research project on the way the researcher’s background and own experiences may ‘colour’ the interpretations, we attempted to avoid that ‘blind spots’ would too much interfere with the analysis.

**Terminological issues**

In all empirical studies we carried out, subjectivity and discourse were central topics, which are, as we demonstrated, closely linked to each other. The interpretation of the terms however slightly differs across the different studies. Therefore, some clarification is indicated. Subjectivity was described by Avdi and Georgaca (2009, p. 655) as “complex, distributed and fragmented, permeated by social and discursive processes, yet intimately personal, as the subject invests theses processes with desire and turns them to the very stuff of his or her being”. In our studies, different aspects of this definition came to the fore. In the first study (Chapter 2), subjectivity mainly referred to the way GPs experience and make
sense of their everyday practice, each in their very personal way. These sense-making processes and perspectives are assumed to be rooted in language as well as expressed through language; therefore, we focused on what was said and how it was phrased. In the studies on Balint groups (Chapter 4 and 5), we refined this interpretation of subjectivity by emphasizing the difference between ego and subject in the way this was expounded by Jacques Lacan. More precisely, we discerned the one-dimensional aspect of the ego (with its typical aim to understand) from the divided, contradictory subject, which at certain moments became more prominent during the BG meetings.

The second crucial concept in our studies is ‘discourse’. Analogously to ‘subjectivity’, the use of the term ‘discourse’ slightly differed over the different studies. In Chapter 2, four different discourses resulted from our analysis of GPs’ narratives about ‘good’ and ‘bad’ consultations. We presented the discourses as different interpretative frames through which professional reality is perceived and constructed; we discerned them on the basis of jargon words that mainly reflect differences with regard to content. In Chapter 5, discourses were central as well. However, in this study, we used a previously conceived distinction between different discourses (i.e. Lacan’s theory of the four discourses) as framework to analyse our data. In Lacan’s theory, discourses are principally different types of social bonds, not intrinsically related to a specific content. Hence, structural aspects prevail, which is exactly why these discourses are a valuable instrument to investigate processes and interactions (in this case, occurring in Balint groups).

**Practical implications**

**Room for subjectivity**

The results of our first study indicate that each of the participating GPs make sense of their everyday practice in their own particular way, or put differently, that they are subjectively implied in the way they perceive their interactions with patients. In this regard, subjectivity is not apprehended as the mere opposite of ‘objectivity’ or ‘scientific attitude’ and thus as something that – from some point of view – should be excluded from medical practice. From a psychoanalytic perspective, subjective implication is not surprising, nor problematic; it is but inherent to the fact that ‘speaking beings’ are ‘subjects’. As noted
before, subjective implication is especially prominent in professions where human interactions are at the core of the profession. Moreover, in professions where asymmetrical or power relations are at stake (such as in the doctor-patient relationship), this might have all the more consequences. As said, subjectivity is not ‘problematic’ \emph{per se}, but its suppression or ignorance possibly is. This was for instance illustrated by the findings of our first study: GPs’ specific ways of speaking about and thus of giving sense to their practice could be linked to the experience of specific difficulties.

In their study about subjectivity at work, Arnaud and Vanheule (2007) pointed at the need for a place to verbalize subjectivity: “Our experience teaches us that paying attention to subjectivity removes the necessity for this subjectivity to find its expression in aspects of the organization’s regular functioning, which then presents itself as irrational or pathological” (p. 365). It is indeed a fact that GPs are prone to, for instance, burnout, substance abuse, work leave and suicide (e.g. Bria, Baaban & Dumitrescu, 2012; Milner, Spittal, Pirkis & LaMontagne, 2013; Soler et al., 2008). No exact prevalence of burnout among GPs is available for Belgium (Fédération des maisons médicales, 2005; Jonckheer et al., 2011). Although many factors do play a role in the development of burnout (see for instance Bria, Baaban & Dumitrescu, 2012; Lee, Brown & Stewart, 2009), one of the contributing factors is found in the relationship with patients (Bakker, Schaufeli, Sixma, Bosveld & Van Dierendonck, 2000; Moreno-Jiménez, Gálvez-Herrer, Rodríguez-Carvajal, Sanz Vergel, 2012).

The 2011 KCE (Federaal Kenniscentrum voor de Gezondheidszorg) report on burnout among GPs suggested the use of Balint groups as one of the preventive strategies for burnout. Although the literature review we performed did not provide strong evidence for the prevention of burnout by means of BG participation, our own empirical studies of Balint groups do support the hypothesis that participation in BGs helps GPs coping with patient-related difficulties.

Interestingly, the importance of making room for subjective expression and exploration also became apparent in the interviews as context: some participants discovered new perspectives or questioned aspects of their work merely through their search for an answer to open-ended interview questions. Some even expressed gratitude for the opportunity the interview gave them to speak and to reflect about their work, which in our view clearly
indicates the need for such opportunities. A different and more formalised platform for such expression and exploration can be found in Balint groups.

**Balint groups**

After observing and analysing the way Balint groups function, we argue that Balint groups can be places where subjectivity can unfold and be explored. This not only possibly benefits the doctors: as it is clear that perceptions affect interactions and even decision making, this can also affect the care for patients. However, at the same time, the work in Balint groups might not suit all GPs, since some interest in exploring subjectivity is required. As said before, we are not advocates of mandatory groups. Nonetheless, through the interviews we performed with Flemish GPs, it appeared that several GPs were confronted with difficulties that could get a place in Balint groups. A renewed creation of Balint groups in Flanders (as was the case in the 1970s-1980s) should therefore be considered.

**Use of study papers**

A further practical implication of the studies we carried out lies in the potential use of the study papers for reflective purposes. The empirical studies we accomplished can provide a framework to help GPs reflect on how they construct their practice and the difficulties their perceptions may involve. The presentation of the different discourses we discerned as well as the examples provided could for instance be used as the onset of a discussion in medical training about ways of making sense of practice or difficulties in the professional context. Moreover, both studies of Balint group work may provide a reflection tool for BG leaders, as they have a special and difficult task in preserving the unique functioning of Balint groups, but at the same time enabling the adaptations the group might need. Finally, the review study of Chapter 3 can be used for future BG research; we will come back to this.
STUDY LIMITATIONS AND SUGGESTIONS FOR FUTURE RESEARCH

Study limitations

The studies presented in this dissertation have a number of shortcomings. First, we note some limitations with regard to the samples used. In our studies, only Belgian GPs and Belgian Balint groups (completed with one Balint group in the Netherlands) participated, which means that our findings almost only regard Belgium. However, performing the literature review as well as participating in an international Balint conference supported the idea that Balint groups in different countries function in a rather similar way. Furthermore, considerations with regard to the sample used also concern the review study we performed. For this review, only English-language and papers published in scientific journals were included, although articles in other languages as well as books and papers from national Balint societies may contain interesting food for thought.

Secondly, the number of Balint group sessions we studied at close quarters was limited. We chose to start with studying the dynamics in Balint groups at case level; the larger data set could be used for further research. Nevertheless, the large amount of cases that were not analysed at close quarters served as background information with regard to the general apperception of what BG work is.

Thirdly, in each of the empirical studies, we mainly relied on one major type of data, i.e. interviews in Chapter 2, and field notes and audio-tapes in Chapters 4 and 5. For all studies, this proved to be a rich source of data material. However, triangulating our data with for instance observations of actual GP-patient consultations for the study in Chapter 2, or with interviews with BG leaders and/or participants for the studies in Chapters 4 and 5 could have been a fruitful completion of the data. However, gathering qualitative data and subsequently analysing them according to data-analytic methods are intensive and time-consuming processes (Hill, 2006), which necessarily limits the possibilities.

Finally, due to the restricted time frame for completing this PhD, the results of our Balint group studies have only limitedly been presented to and discussed with people working in Balint groups. A small part of our research was presented at the two-year international Balint conference and it is also planned to present our results to the Belgian Balint Society.
Future research

The literature review we performed proved to be very instructive with regard to suggestions for future research. As we ourselves had never heard of Balint groups during medical training, we were quite surprised to find a number of articles on this topic. However, we were also surprised by the lack of quality some papers exhibit. Nevertheless, we also came across some critical reflective articles and some qualitative method papers that were informative on several aspects. In our own empirical research in Balint groups, we mainly focused on the way Balint groups function and we did not investigate other aspects of Balint group work. However, through the literature review, we learned that a challenging difficulty lies in the conception of well designed outcome studies. In the first place, longitudinal studies require a rigorous organisation. Furthermore, the demarcation of meaningful variables appears to be a difficult undertaking. Indeed, performing quantitative research implies that researchers define in advance what they are looking for. This evidently limits the scope of research results. This difficulty is definitely not a characteristic exclusive of Balint group research; it is also the core of a vivid debate for instance in the context of psychotherapy outcome research (Hill, Chui & Baumann, 2013). Qualitative research in which participants get the opportunity to fully describe their experiences from their perspectives might therefore be a useful alternative to questionnaires with pre-defined outcome parameters (Hill, Chui & Baumann, 2013). Therefore, further qualitative research as well as genuine preliminary discussions on the parameters that will be used is recommended. Such qualitative research might for instance include inviting (ex-)BG participants to speak about the way they experienced their participation in a Balint group. This might provide a better understanding of the potential value as well as the negative sides of Balint groups.

Furthermore, with regard to our own data, many avenues for further research are open. As said, we have a rich data set at our disposal, that could be used for further investigation. Until now, we mainly studied cases at a micro-level. Analyzing the larger data set, making comparisons between the different Balint groups, studying the evolution of individual participants over one year of participation or focusing on the interventions of BG leaders could for instance be considered.
Finally, for the present research project, we focused on the specificity of Balint groups by studying Balint group sessions from the inside. Studying related types of groups or forms of CME at the same depth could provide us with insights allowing for a more precise comparison of different initiatives.

CONCLUSION

Through the different studies we executed, GPs’ subjective implication in their medical practice was a central focus. As subjectivity is intrinsically linked to the way GPs make sense of their practice, it is certainly not something that should or even could be excluded. Along with other authors (Arnaud & Vanheule, 2007), we even argued that subjectivity needs to get a place in order not to get pathological expression. Such expression can, for instance, take the form of repeated confrontations with the same type of difficulties. As the medical context tends to be demanding, prescriptive and focused on efficiency, we are convinced that a counterbalance is needed. Our study shows that Balint groups can provide (part of) such counterbalance, by providing time for exploration of personal experiences and for critical reflection.
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Nederlandstalige samenvatting

Ervaringen en moeilijkheden binnen de arts-patiëntrelatie en de mogelijke rol van Balintgroepen: een kwalitatieve studie bij huisartsen
THE ILLNESS, THE PATIENT... AND THE DOCTOR?

De vorige eeuw werd gekenmerkt door een opmerkelijke evolutie in het medisch discours. Na decennia van dominantie van een biomedisch en eerder paternalistisch model van de Westerse geneeskunde, deden meer holistische en patiëntgerichte benaderingen hun intrede midden de 20e eeuw. Het opduiken van noties als ‘biopsychosocial medicine’ (Engel, 1977) en ‘patient-centeredness’ (Mead & Bower, 2000) getuigen hiervan. Deze verschuiving gaat hand in hand met de erkenning van het belang van de arts-patiëntrelatie, die een des te prominentere plaats krijgt binnen de huisartsgeneeskunde (Bower et al., 2001; May, Dowrick & Richardson, 1996). Eén van de pioniers die het belang van de arts-patiëntrelatie vooropstelde was Michael Balint (1896-1970), die stelde dat “by far the most frequently used drug in general practice was the doctor himself” (Balint, 1964, p. 1). Dit is in overeenstemming met de bevinding dat in psychotherapie de ‘therapeutische alliantie’ of ‘werkalliantie’ een cruciale curatieve factor is (Drisko, 2004; Horvath, 2013; Martin, Garske & Davis, 2000).

Over de arts-patiëntrelatie is in de wetenschappelijke literatuur één en ander te vinden, hoewel onderzoek over dit thema toch beperkt blijft als we het vergelijken met de hoeveelheid onderzoek naar zuiver biomedische onderwerpen. Onderzoek naar de arts-patiëntrelatie betreft beschrijvingen van verschillende soorten arts-patiëntrelaties (voor een overzicht zie o.a. Oprea, 2009), bestudeert aspecten ervan (e.g. Horder & Moore, 1990; Huygen et al., 1992), outcome effecten van bepaalde types van arts-patiëntrelatie (e.g. Franks et al., 2006) of moeilijkheden in deze relatie. Met betrekking tot dit laatste vinden we nogal wat onderzoek dat “the difficult patient” (e.g. Corney et al., 1988; Haas, Leiser, Magill & Sanyer, 2005; Schafer & Nowlis, 1998; Steinmetz & Tabenkin, 2001), “the problem patient” (e.g. Drossman, 1978; Kaufman & Bernstein, 1957), “the hateful patient” (e.g. Groves, 1978; Levinsky, Friedman & Levine, 1999; Strous, Ulman & Kotler, 2006), of “the heartsink patient” (e.g. O’Dowd, 1988; Mathers, Jones & Hannay, 1995) centraal stelt. Andere auteurs opperen dan weer dat het correcter is om te spreken van “difficult doctor-patient relationships” of “demanding encounters” eerder dan van “the difficult patient” (e.g. Nisselle, 2000; Sledge & Feinstein, 1997; Smith, 1995; Stacey, Henderson, MacArthur & Dohan, 2009). Slechts een kleine groep onderzoekers bekijkt dit ook eens van de kant van de arts en beschrijft arts-gerelateerde factoren die bijdragen tot het ervaren van patiënten als

Wanneer we dit wetenschappelijk onderzoek met betrekking tot de arts-patiëntrelatie van naderbij bekijken, vallen drie zaken op. Ten eerste focust dit onderzoek voor een groot deel op de patiënt (zie bijvoorbeeld de literatuur rond “patient-centeredness”, “patient satisfaction” en zelfs “the difficult patient”). Dit is voor een stuk te begrijpen vanuit de reeds aangehaalde verschuiving van een overwegend biomedisch en paternalistisch naar een meer holistisch en patiëntgericht model van de geneeskunde, wat zeker lovenswaardig is. Echter, de kant van de arts is veel minder belicht. Ten tweede lijkt de verantwoordelijkheid van de arts in de arts-patiëntrelatie zich hoofdzakelijk te situeren in het verwerven van allerhande vaardigheden of ‘skills’ (vb empathie, communicatie skills of patient-centeredness). Hoewel het aanleren van skills zeer zeker zijn waarde heeft, merken we op dat dergelijke aanpak erg prescriptief van aard is en ervan uit gaat dat artsen ‘uniform’ zijn in de manier waarop ze dingen ervaren en aanleren. Bepaalde auteurs hebben dit ook aangestipt. Zo vonden Smith, Dorsey, Lyles and Frankel (1999) bijvoorbeeld dat attitudes bepalend zijn in het aanleren van skills en benadrukten Hall, Horgan, Stein and Roter (2002) dat onderzoek over de arts-patiëntrelatie vaker focust op het gedrag en de skills van artsen en patiënten eerder dan op motivatie en emoties, die nochtans een impact kunnen hebben op het gedrag van artsen en patiënten. Ten derde worden in het onderzoek naar moeilijkheden in de arts-patiëntrelatie veeral geïsoleerde factoren, kenmerken of gedragingen bestudeerd, waarbij de dynamiek en de complexere interacties tussen verschillende aspecten achterwege blijft.

Wat nu met de dokter? Het is een feit dat de geneeskundige praktijk gekenmerkt wordt door onzekerheid en complexiteit op vele vlakken (Sweeney, 2006). Eén antwoord hierop ligt in het opstellen van richtlijnen die artsen ongetwijfeld kunnen helpen. Onderzoek toont echter aan dat er heel wat obstakels blijken te zijn bij het implementeren van deze richtlijnen. Eén van deze obstakels blijken de artsen zelf (Cabana et al., 1999; McKenna, Ashton & Keeney, 2003). Artsen zijn inderdaad niet louter professionals die richtlijnen toepassen of informatie verwerken; het zijn ook mensen die betekenis verlenen aan de interacties die ze hebben met patiënten, aan hun professionele rol en aan hun alledaagse praktijk. Epstein (1999) wees er bijvoorbeeld op dat een klinisch oordeel door emoties, vooroordelen, en tolerantie voor onzekerheid beïnvloed wordt. Zo ook beklemtone Novack et al. (1997) dat persoonlijk
verleden en achtergrond, waarden, attitudes, en emotionele ‘hot buttons’ de reacties van artsen tegenover hun patiënten beïnvloeden. Niet alleen beïnvloeden deze factoren de interactie met patiënten, ze geven ook vorm aan die interacties. Dit is krachtig geformuleerd in het idee dat artsen zichzelf als instrument gebruiken in hun werk (Novack et al., 1997) of in de reeds aangehaalde stelling dat de arts het meest gebruikte medicijn is voor de patiënt (Balint, 1955). Hoewel deze factoren dus een grote impact kunnen hebben, blijven ze vaak onbewust. Immers, als dokters zichzelf als instrument gebruiken of als geneesmiddel toedienen, moeten ze respectievelijk ‘gekalibreerd’ (Novack et al., 1997) of ‘farmacologisch getest’ (Balint, 1955) worden. In deze context vinden we in de literatuur inderdaad termen als ‘personal awareness’ (e.g. Borrell-Carrió & Epstein, 2004; Novack et al., 1997; Smith et al., 1999; Smith, Dwamena & Fortin 2005), (self-)reflection (e.g. Clarke, James, & Kelly, 1999; Plack & Greenberg, 2005; Bethune & Brown, 2007, ‘reflexivity’ (Baarts, Tulinius, & Reventlow, 2000) of ‘mindful practice’ (Epstein, 1999). Sporadisch gaat er in medische opleidingen ook aandacht naar deze aspecten (dit is vooral zo in de US). Soms worden ook Balintgroepen in deze context vernoemd. Aangezien de arts-patiëntrelatie in Balintgroepen een centrale focus vormt en deze groepen wereldwijd voorkomen (met inbegrip van België), besloten wij hier dieper op in te gaan.

BALINTGROEPEN

Als zoon van een Hongaars arts, raakte Michael Balint (1869-1970) al vroeg geïnteresseerd in de arts-patiëntrelatie. Zelf studeerde hij geneeskunde, behaalde een doctoraat in de biochemie en werkte als psychoanalyticus (Swerdlöff, 2002). Wanneer hij in de jaren ’50 van de vorige eeuw in de Londense Tavistock Clinic werkte, groeide het idee om seminaries voor huisartsen op te starten, waarbij er vooral aandacht zou gaan naar de psychologische aspecten van de medische praktijk (Balint, 1969; Horder, 2001; Lakasing, 2005). Deze groepen zouden later de naam ‘Balintgroepen’ krijgen. Dit is te situeren in het naoorlogse Engeland, waar de huisartsgeneeskunde onder druk stond en artsen vaak (getraumatiserde) patiënten met psychosomatische klachten over de vloer kregen, waarvoor zij niet opgeleid waren. Na het overlijden van Michael Balint zijn Balintgroepen wereldwijd beginnen ontstaan, zij het steeds op beperkte schaal (Salinsky, 2002). Vanaf 1972
werden er ook Internationale Balintcongressen georganiseerd en zagen nationale en internationale Balintfederaties het daglicht (Salinsky, 2002).

Wat zijn Balintgroepen nu precies? Balintgroepen tellen gemiddeld zes tot twaalf deelnemers en één of twee groepsbegeleiders en komen eenmaal per week tot eenmaal per maand samen. Sommige groepen richten zich enkel op huisartsen, andere groepen verwelkomen (ook) verpleegkundigen, kinesisten of geneesheer-specialisten. Er wordt expliciet naar gestreefd dat deelnemers in Balintgroepen niet professioneel samenwerken, dit om het vrij spreken maximaal te bevorderen. De groepsbegeleiders hebben meestal een medische, psychologische en/of psychoanalytische achtergrond; hun taak bestaat voornamelijk uit het faciliteren van het spreken en het bewaken van de veiligheid van elkeen (Johnson, Nease, Milberg, & Addison, 2004).

**OPZET EN OVERZICHT VAN DE BEVINDINGEN**

Het opzet van deze doctoraatsverhandeling lag in het exploreren van de kant van de arts in de arts-patiëntrelatie. We focusten hierbij op de moeilijkheden die huisartsen in hun werk met patiënten ervaren en de mogelijke rol die Balintgroepen hierbij kunnen spelen. Omdat we hierbij de narratieven van de participanten centraal stellen, was een kwalitatieve onderzoeksmethode het meest aangewezen. Taal speelt een centrale rol, zowel wat betreft onze data (interviews en opnames van Balintgroepsessies) als de data-analytische focus. Taal was eveneens een cruciaal interessepunt van psychoanalyticus Jacques Lacan (1901-1981); meer bepaald zullen zijn noties van ‘subject’ en ‘discours’ een belangrijke rol spelen in een aantal van onze studies. In de volgende paragrafen worden de onderzoeksvragen, gebruikte methodologie en resultaten van de verschillende studies waaruit dit doctoraat bestaat, nader toegelicht.

In een eerste studie gingen we nader in op de betekenis die huisartsen verlenen aan hun dagelijks werk met patiënten en op de manier waarop ze hierover spreken. We stelden ons hierbij de vraag of we verschillende soorten discours in hun narratieven konden onderscheiden en welke de eventuele implicaties van deze discours zijn. Hiervoor namen we een semi-gestructureerd interview af bij 19 huisartsen. We bevroegen hen over wat zij als
goede en slechte consultaties ervaren en moedigden hen aan om vrij te spreken en in te gaan op aangehaalde voorbeelden. In deze narratieven onderscheidden we een aantal centrale thema’s, problemen waar deze huisartsen graag mee omgaan en typische moeilijkheden waarmee ze geconfronteerd worden. Deze analyse resulteerde in de identificatie van vier verschillende discours: een discours gericht op biomedische aspecten, een discours gericht op communicatie, een discours gericht op probleem-oplossing en een discours gericht op voldoening. Elke deelnemende huisarts bleek een individueel verschillende mix van elementen uit één of meerdere discours te gebruiken. Dit toont enerzijds aan dat artsen hun praktijk niet op een uniforme wijze ervaren en er betekenis aan verlenen. Anderzijds impliceert een voorkeur voor bepaalde discours ook een sterkere confrontatie met de moeilijkheden of de beperkingen eigen aan dit specifieke discours. Een dergelijke koppeling tussen de focus op een bepaald discours en de confrontatie met bepaalde moeilijkheden werpt dus mogelijk een nieuw licht op moeilijkheden die artsen in de arts-patiëntrelatie kunnen ervaren. Vanuit de literatuur leek het ons dat Balintgroepen net een forum te bieden om het perspectief van waaruit een moeilijkheid wordt gekaderd te exploreren.

Aangezien de wetenschappelijke literatuur over Balintgroepen zeer versnipperd bleek en we soms ook botsten op tegenstrijdige onderzoeksbevindingen, besloten we een overzicht van de wetenschappelijke literatuur over Balintgroepen te maken. Een zoektocht doorheen ‘Web of science’ en ‘Pubmed’ leverde 35 empirische (kwantitatieve en kwalitatieve) en 59 niet-empirische Engelstalige artikels op. De onderzoekstopics van de empirische artikels bleken zeer divers en bovendien waren verschillende artikels methodologisch zwak. Hierdoor konden geen overkoepelende conclusies getrokken worden. We bundelden de verschillende onderzoekstopics in een overzicht en onderscheidden verschillende outcome maten (vb psychosocial self-efficacy, burn-out, verschillende attitudes), kenmerken van Balintgroep-participanten, thema’s die in de groepen aan bod komen, processtudies, onderzoek naar Balintgroep leiderschap, groepsevaluaties, aanwezigheid en drop-outs. Omdat het ons doel was om een zo breed mogelijk overzicht te krijgen over wat er in de wetenschappelijke literatuur over Balintgroepen geschreven is, kozen we ervoor om ook de niet-empirische artikels in dit overzicht op te nemen. Deze betroffen reflectieve artikels, papers met hoofdzakelijk historische en/of geografische informatie, en verslagen of getuigenissen van
Balintgroepdeelname. Vooral in de reflectieve artikels, kwalitatieve studies en getuigenissen vonden we aanwijzingen voor de waarde van Balintgroepen. We besloten deze review met een aantal opmerkingen naar toekomstig onderzoek toe.

Vervolgens voerden we in een derde en vierde studie zelf empirisch kwalitatief onderzoek naar Balintgroepen uit. We beoogden meer inzicht te verwerven in het type moeilijkheden dat in Balingroepen aan bod kan komen, in de manier waarop het perspectief op deze moeilijkheden evolueert tijdens Balintgroepbijeenkomsten en de specifieke werkingsmechanismen van Balintgroepen. Gedurende 15 maanden (van april 2011 tot juni 2012) observeerden we – niet-participatorisch – de maandelijkse bijeenkomsten van vier verschillende Balintgroepen. Aangezien er heden ten dage geen Balintgroepen meer zijn in Vlaanderen, vonden we deze groepen Brussel-Wallonië (drie groepen) en in Nederland (één groep). In totaal observeerden we 45 bijeenkomsten (waarin 87 casussen aan bod kwamen), waarvan er 33 (68 casussen) auditief geregistreerd werden. Twee groepen bestonden louter uit huisartsen, twee andere waren gemengd (huisartsen, verpleegkundigen, kinesisten, specialisten).

In onze derde studie analyseerden we twee casuspresentaties en de daaropvolgende groepsdiscussies in detail. Vanuit de vaststelling dat er wel degelijk ‘iets’ beweegt in de casus tijdens de Balintbijeenkomst, beoogden we dit proces te beschrijven en te analyseren. Hiervoor bleek het Lacaniaanse onderscheid tussen een imaginaire en symbolische verhouding tot de ander, of anders gezegd tussen ego en subject, bijzonder relevant. In beide casussen bleken de presenterende huisartsen aanvankelijk vast te zitten in een gefixeerd beeld van de moeilijkheid waarmee ze geconfronteerd werden. Doorheen een reeks van interacties met de groep werden deze artsen aangemoedigd om verschillende subjectposities te exploreren. Dit zorgde ervoor dat hun initieel perspectief op de moeilijkheid werd opengetrokken of geherformuleerd. In de vergelijking tussen beide casussen merkten we op dat mate van ‘verandering’ die plaatsvond ook afhankelijk was van de bereidheid en het verlangen van de presenterende arts om nieuwe elementen op te pikken en verder te elaboreren.

In onze vierde studie streefden we naar een breder en iets abstracter begrip van de werkingsmechanismen van Balintgroepen. Hierbij bood de discoursstheorie van Lacan ons
een bruikbaar handvat. Startend bij een nauwgezette lezing van vijf Balintgroep casussen, groeide tijdens de onderzoeksbijeenkomsten een meer overkoepelend begrip van wat er in deze groepen (al dan niet) werkzaam is. Het gebruik van de discourstheorie liet ons toe om de initiële ‘moeilijkheden’ die de artsen in Balintgroepen presenteerden te lezen als een confrontatie met wat in de Lacaniaanse discourstheorie de ‘disjunctie van onmogelijkheid’ heet. Vervolgens begrepen we het doel van Balintgroepen als een proces van ‘hysterisering’, wat op zijn beurt gestimuleerd wordt door het analytisch discours. Het analytisch discours bleek zowel door de groepsbegeleiders als door andere participanten gehanteerd te worden. Tenslotte zagen we de interacties tussen de verschillende discours als een cruciaal werkingselement van Balintgroepen precies doordat deze ‘switches’ de mogelijkheid creëren het initieel perspectief op de moeilijkheid in kwestie iets van zijn aanvankelijke starheid en beperktheid te doen verliezen.

**DISCUSSIE**

In de discussie van deze doctoraatsverhandeling stonden we bij een aantal zaken stil. In de eerste plaats vergeleken we de moeilijkheden of de beperkingen van de discours die we in onze eerste studie beschreven met de moeilijkheden die de Balintgroep participanten presenteerden in de geobserveerde Balintgroepen. We concludeerden dat een substantieel deel van deze moeilijkheden met elkaar overlapt en besloten dat Balintgroepen een forum bieden voor een aantal moeilijkheden waarmee huisartsen in hun dagelijkse praktijk geconfronteerd worden. Vervolgens gingen we wat dieper in op de specificiteit van Balintgroepen. Dit leek ons van belang aangezien Balintgroepen – voor zover ze al bekend zijn – soms als historische curiosa beschouwd worden (Lustig, 2006) en dat men soms stelt dat de functies van Balintgroepen door andere vormen van voortgezette medische opleidingen overgenomen werden. Op basis van onze studies menen wij dat Balintgroepen een eigen karakter hebben en dat zij een forum kunnen bieden voor nog steeds heel actuele noden van artsen (en andere professionelen die met patiënten werken). Zo wezen we bijvoorbeeld op de punten waarin Balintgroepen verschillen van bijvoorbeeld supportgroepen, probleemoplossingsgroepen en reflectiegroepen. We stonden ook kort stil bij de factor ‘tijd’ die op verschillende vlakken een rol speelt in Balintgroepen. We
benadrukten dat het in Balintgroepen veeleer over ‘verandering’ (change) gaat dan om leren, meer om een ondervragen dan het aanreiken van kennis of technieken. Via een korte teruggang naar onze lezing van Balintgroepen vanuit de discours-theorie van Lacan benadrukten we de particulariserende focus van Balintgroepen tegenover het universaliserende van het gangbare medisch discours. Tot slot van de bespreking van de specificiteit van Balintgroepen gingen we ook kort in op de beperkingen van Balintgroepen. Zo stipten we bijvoorbeeld aan dat net vanuit die specifieke focus op hysterisering of het ondervragen van de eigen implicatie in de confrontatie met bepaalde moeilijkheden het niet zinvol lijkt om deelname aan Balintgroepen te verplichten. Dit stemde ook overeen met bevindingen uit onze review van de Balintgroepsscholering over drop-out en negatieve evaluaties van Balintgroepen; deze bleken immers vooral voor te komen in Balintgroepen die in enkele landen verplicht zijn voor artsen in opleiding (Graham, Gask, Swift & Evans, 2009; Musham & Brock, 1994).

Na een korte reflectie over enkele methodologische en terminologische overwegingen bij deze doctoraatsverhandeling, formuleerden we een aantal praktische implicaties. Zo benadrukten we de nood aan het creëren van een forum waar artsen hun subjectieve implicatie in hun werk met patiënten kunnen exploreren. Huisartsen blijken een bijzonder kwetsbare groep voor burn-out, middelenmisbruik, het veranderen van job of suicide (e.g. Bria, Baaban & Dumitrascu, 2012; Milner, Spittal, Pirkis & LaMontagne, 2013; Soler et al., 2008). Hoewel vele aspecten een rol spelen in het ontstaan van burn-out (zie bijvoorbeeld Bria et al., 2012; Lee, Brown & Stewart, 2009), wordt de relatie met patiënten (Bakker, Schaufeli, Sixma, Bosveld & Van Dierendonck, 2000; Moreno-Jiménez, Gálvez-Herrer, Rodríguez-Carvajal, Sanz Vergel, 2012) als één van de factoren naar voren geschoven. Niettegenstaande onze reviewstudie geen overtuigende bewijzen levert dat Balintgroepen preventief zijn in het ontstaan van burn-out, tonen onze eigen studies wel aan dat participeren in Balintgroepen kan bijdragen tot het anders omgaan met moeilijkheden in de arts-patiëntrelatie. Vervolgens menen we dat onze studies als aangrijpingspunt kunnen dienen voor reflectieve doeleinden. Zo kunnen de verschillende discours en voorbeelden uit de eerste studie bijvoorbeeld een reflectie initiëren met betrekking tot de eigen manier van denken over de eigen medische praktijk en de moeilijkheden waarmee men geconfronteerd wordt. Bovendien zouden onze studies over Balintgroepen een reflectie-instrument kunnen
bieden voor Balintgroepbegeleiders die geen eenvoudige taak hebben in het begeleiden van een groep.

Tenslotte wezen we op een aantal beperkingen van onze studies (zoals de beperkte steekproef en de focus op één bepaald type van data) en suggereerden we enkele aandachtspunten voor verder onderzoek. Aangezien onze eigen studies alsook verschillende studies uit onze review de mogelijke kracht en waarde van Balintgroepen aangeven, menen wij dat verder onderzoek over Balintgroepen zinvol is. Mede door de beperkte aantallen Balintgroepen en door de moeilijkheid om de te meten maten op voorhand te bepalen, zijn wij ervan overtuigd dat verder kwalitatief onderzoek over Balintgroepen het meest aangewezen is.
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