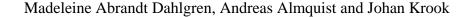
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Physiotherapists in Balint Group Training - some Reflections on an Experiential Journey

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ABSTRACT

Background: Balint group training (BGT) is a widely used method for enhancing understanding of the relationship and communication between therapists and patients. The participants meet on a regular basis in small groups together with a tutor to discuss their experiences of problem cases. The method was originally developed in the 1950s for enhancing understanding of the doctor-patient relationship and is now widely used and recognised all over the world. BGT has also been used for groups other than doctors, even if few studies focus on BGT and physiotherapists. The aim of this study was to describe and analyse physiotherapists' experiences of participation in BGT as a means of learning and understanding the physiotherapist-patient relationship. Methods: Semi-structured, in-depth interviews were conducted with three physiotherapists, working in private practice, all participating in BGT. The interviews were transcribed and subjected to a qualitative analysis. Results: The results are presented in a sequential model, featuring eight themes in which the physiotherapists' experiences of the training process are portrayed. Conclusion: The results suggest that BGT and sharing the experiences of others could be considered a way of enhancing the understanding of the patient encounter in clinical practice, possibly to the benefit of physiotherapists and their patients.

Keywords: Balint group, physiotherapists, experiences, qualitative analysis

INTRODUCTION

's' I went to Paris at tenth time to learn more about

London

Somerset Maugham

Understanding the therapist-patient relationship

In several process models of physiotherapy, a good therapist-patient relationship is considered an important feature of the clinical reasoning process as well as a prerequisite of successful treatment results in physiotherapy (Higgs & Jones, 1999, Tyni-Lenné 1987). Studies of physiotherapy practice have, however, shown that physiotherapists have different conceptions of the socially and professionally constructed basis on which therapies are chosen and co-operation is built (Abrandt, 1997; Westman-Kumlien & Kroksmark, 1992). Findings from these studies show that physiotherapists sometimes tend to take control of and dominate the patient encounter at the expense of the patients' participation in decisionmaking throughout the physiotherapy process (Ek, 1990; Engelsrud, 1990; Thornquist, 1992, 1994 a,b; Abrandt, 1995). These findings might indicate that the physiotherapists have adopted a paternalistic view of their relationship to the patient. An alternative explanation could be that the professional reality includes confrontations between perspectives held by other professional groups in the caring team which differ from or even contradict the professional discourse of physiotherapy (Abrandt, 1997). Similar traits of the communication as of those between physiotherapist and patients have also been shown in studies of encounters between physicians and their patients. Mishler (1984) claims that there exist two voices in encounters in health and medical care. One is the voice of medicine, represents representing the technical-scientific assumptions embedded in the discipline, that is brought into the encounter by the doctor. The other is the voice of the life-world, representing the common conceptions of everyday life, that is brought into the encounter by the patient. Mishler has convincingly shown that the voice of medicine dominates in the professional encounter between physician and patient (ibid.).

As early as in the 1950s, the Hungarian physician Balint pointed out in his book 'The doctor, his patient and the illness' (1957), that physicians tend to develop habitual responses to particular types of patients and problems instead of responding to the uniqueness of each case (Balint, 1957; Balint 1993. Balint developed a method in which, by examining and reflecting on their individual approaches to the patient, the physicians could explore alternative ways of responding to the situation and thereby enrich their repertoire of ways of handling difficult situations (Dornfest & Ransom, 1992). As a parallel process, the enhancement of understanding the patient's problem is also claimed to affect the therapist's ability to intervene therapeutically. A therapeutic intervention in this context is, according to Luban-Plozza (1995) when the therapist can make the patients realise something new about themselves that would eventually lead to a change. BGT is not a theory of personality such as, for instance, transactional analysis (Berne, 1961) nor is it intended for personal therapy. The training is a reflective technique, said to foster new kinds of understanding and interventions (Körner et al, 1988). Today, Balint training has spread throughout the world and is linked through the International Balint Federation, formed in 1972 by the Balint societies in Britain, France, Belgium, Holland and West Germany (Balint, 1993; Ransom, 1995). There are now 12 affiliated National Societies and the

Federation has organised 10 International Balint Conferences (American Balint Society, 1997).

The process of BGT

Balint groups meet regularly with a trained leader to discuss the physicianpatient relationship. Ideally, groups range in size from six to 12 members and remain together for about three years, although experience shows that shorter periods of training than three years are dominant and that drop outs are common (Balint et al 1966; Musham & Brock, 1994). Depending on time constraints, meetings can vary from weekly two-hour sessions to semi-monthly, one-hour gatherings. The Balint process always focuses on an real case, which is discussed in detail. In this respect, the format is similar to action learning sets, where participants learn through working with 'real' problems (Mumford, 1996). At the same time, it is different from action learning sets in that BGT has its emphasis on the psychological dimension and on reflection. Problems related to patient psychology or personality, physician-patient relationship, patient's family, or physiciancolleague relationship are areas that often emerge from the discussion. A central goal is to transform the abstract, general biomedical assumptions into the particulars of a patient's life (Ransom, 1995). Originally, group leaders were always psychoanalysts with a special interest in this sort of work, and this is still the case in some countries. However, in the UK and the USA, BGT groups are usually lead by experienced family doctors and clinical psychologists.

Physiotherapists in Balint Group Training

There are not many studies of physiotherapists in BGT available. Kindler (1984), however, argues that also physiotherapists could benefit from participating in BGT. She claims that physiotherapists, who work alone,

especially those who work in public health care, need support from a Balint group in order to better understand the physiotherapist-patient relationship, and in order to improve their practice. Kindler's study also shows that BGT could evoke both positive and negative feelings within the participators. The training could give sudden insights that helped physiotherapists to understand their patients and thereby better plan and carry out the treatment. Some physiotherapists left the group, finding their professional situation becoming too complex when they could no longer rely solely on the patient's physical symptoms, but also had to try to take the patients' emotional and social situation into account when planning and carrying out treatment (ibid.).

The aims of the study

The physiotherapists included in this study were all Swedish, and they all worked in private practice. Working in private practice in Sweden often means that the physiotherapist works alone, in a small clinical setting, without the psychosocial network that colleagues can provide. The aims of the present study were to describe and analyse private practising physiotherapists' experiences of participation in BGT as a process and as a means of learning about and understanding the physiotherapist-patient relationship.

The empirical study

The informants consisted of physiotherapists, who had enrolled and participated in a Balint group for 18 months and who consented to participate in the study. The group met regularly once a month. The group leader was a physiotherapist with psychotherapist training, who had adopted the ideas of Balint training and applied them to physiotherapy.

The participating physiotherapists had long experience of working with patients, i.e. years in practice varied from nine to 30. They shared an interest in working with patients with psychosomatic problems, or with patients suffering from chronic pain.

Data collection and analysis

Three physiotherapists agreed to participate in the study and were interviewed in depth about their experiences of participating in the group. All interviews were tape recorded, subsequently transcribed and subjected to a qualitative analysis with an interpretative phenomenological approach (Huberman & Miles, 1994; Lawler, 1998). Metaphors are used to give structure to the presentation. The use of metaphors to increase readability is a commonly used methodological device in qualitative studies (Richardson 1990; Miles & Huberman, 1994; Kvale 1996). The rationale for using metaphors is that they are data-reducing pattern makers and that they provide opportunities for experiencing and understanding one thing in terms of another. Richardson (ibid.) claims that "metaphors external to the particular piece of research pre-figure the analysis with a 'truth-value' code belonging to another domain"(p. 519), that is familiar and helps the reader to construct a coherent whole. The procedure of analysis and process for writing up this study can be schematically described as follows:

Phase 1: Each transcript was thoroughly and repeatedly read by the authors separately, significant statements were coded and a number of preliminary themes within the interviews were formed.

Phase 2: The separate analyses were compared and, via a process of intersubjective interpretation and critical negotiation between the authors, the emerging themes were refined. The aim of this phase was the search for the common essences within and between the interviews.

Physiotherapists in Balint Group Training

Phase 3: The final eight themes, representing the participants' interpretations of their experiences, were arranged sequentially with respect to temporal occurrence in the training process. Representative quotations from the interviews were chosen to label the themes. Adjacent to the description of the emerging themes, the authors' theoretical associations and reflections were added.

Phase 4: Four general stages in the Balint training process, each made up of two of the themes, were discerned and presented metaphorically as phases of a symbolic journey.

RESULTS

(Insert figure 1 about here)

I. Starting out: Checking the baggage

The incentives for starting out on the journey could be traced in the participants' baggage of concrete experiences from their everyday work with patients. These experiences comprised different expressions of difficulties in establishing a well-functioning contact with patients. The feeling of 'Beating around the bush' or 'Feeling frustrated' form the first stage in the training process and is further elaborated on in the following:

"Beating around the bush"

The physiotherapists had a feeling that although they were experienced in their fields and well-educated, they lacked the competence to handle difficult cases, since they felt that they could not truly reach the patient. Some quotations from the interviews illustrate this; 's'/../ I have worked in primary health care, I have worked with rheumatology...and in orthopedics..I went to all these courses, and found them very important...and still, it is not enough..

Another reason for enrolling in Balint training was the burdensome feeling of working with 'heavy' patients. The physiotherapists had difficulties in letting go of their thoughts about the patient even during their leisure time.

's'/../ And after I had been working on my own for some time I felt that I tended to have patients who...in a way..oppressed me. And I didn't really know how cope with the problem, there was more to it than just the physiotherapy treatment..

The researchers' interpretation of the physiotherapists' feelings of being insufficient was that they express as a certain kind of insight, that something is problematic in the interaction between therapist and patient. However, it is not clear from the informants' statements whether it was the patient, the therapist or perhaps a combination of both that was problematic. A theoretical illumination of the results at this stage is provided by Holm (1995), who has described how therapists and patients affect each other both cognitively and emotionally in the encounter and the interaction. This interpretative and emotional process in a communicative encounter is described as affective resonance. Our data give some evidence that this process also is of particular relevance to the physiotherapy context. Physiotherapists often get very close to their patients, both physically, through touch, and mentally through the close relationship. The physiotherapists' descriptions could be interpreted to mean that physical touch adds a further dimension to the process of interaction and communication between the two parties. One informant commented on this as follows;

's'/../ When I graduated about thirty years ago I worked a lot with orthopaedic manual medicine..and in the work, you stand real close up to the patient, literally embracing him/her, holding real tight...And you never spoke of the feelings that it evoked...But it does, doesn't it, both in the therapist and in the patient..But that was a taboo subject...nobody spoke about that...

"Feeling frustrated"

The second theme describes the feeling of insufficiency or not being able to establish a good relationship with the patient. This leads to a more or less conscious feeling of frustration in the physiotherapists. One of them commented;

's'/../Sometimes I feel aggressive and angry at a certain patient..and that frightens me a little, because we're supposed to be neutral in some way, to meet all patients in the same way, everybody is entitled to get the treatment he needs..And it makes me kind of puzzled, why do I feel this way towards this patient?

Here, a psychological construct was useful for the researchers' interpretation of the physiotherapist's description of the interactive process. The concepts of transference – countertransference means that the patient's and the physiotherapist's subconscious feelings are transferred from one field of experience to another (Phares & Trull, 1997). The patient is probably more or less frustrated in the first place, due to the disorder that

causes him see the physiotherapist. This frustration could easily be transferred to the physiotherapist in a negative way. The situation could also be complicated by the physiotherapist transferring her frustration over not being successful to the patient.

II. Meeting other perspectives: Listening and adjusting

As a newcomer in a new country, the traveller is confronted with a new culture. The language is different and other perspectives of well-known phenomena are discernible. The traveller, more or less consciously, compares the experiences from home with the new ones through reflective observation. This also involves abstract conceptualisation of new concepts and information. Some features could be similar to those at home, but others might seem strange and unfamiliar. Gradually, the traveller begins to adjust to the customs of the new country, adopting the parts that seems to fit and leaving out the parts that seem to strange. The informants in this study described similar experiences from taking part in the training, how they were 'listening and recognising' and how adjustments were made, 'Tuning your instrument..'

"Listening to others, recognising"

The participants in the Balint group shared their experienced problems with each other. Sharing experiences in the group means that the participants had to verbalise feelings and thoughts in order to make the others understand. In this process, the problems were more clearly expressed and articulated. A clearer structuring of the problem from the participants' own perspective was achieved, as commented on below;

's'/../ Maybe I can't always see clearly on my own...That would require a good self-knowledge..The comments from the group leader are important..And that I hear from someone else...and then I recognise a little, what am I doing, really...

"Tuning your instrument"

This theme describes the participants' experiences of the impact of verbalising, discussing and reflecting on the experienced problems and frustrations in the patient encounter having been directly or more gradually developed during the training. The direct impact could be an ahaexperience, meaning the sudden grasp or understanding of relationships that illuminate experience or help to solve a problem, as expressed in the quotations below:

's'/../In some cases I feel; well, that is not me..! I don't recognise that in me..Maybe I did, but I don't have problems with that anymore...I make that kind of reflection as well... So I sort of tune...I sort of tune my instrument by listening to the others... And that is good...To get some confirmation...

Discussing complex situations did not always have a direct impact like an aha-experience, but a more gradually developed understanding of and insight in the processes and phenomena involved. The tutor also contributed to a broadening and deepening of the participants' understanding of the problem. Two of the participants commented on this as follows:

's'/../ Even if I did not bring a case of my own, I recognise myself in the problems that the other participants have brought..And many times, after

the sessions you feel relieved, yes, almost euphoric sometimes...and you keep on pondering afterwards..on what we talked about...well, you bring it with you, it is not over and done with when the session is over...you keep on reflecting...and you learn a lot from that...

Another characteristic feature of the participants' descriptions of this phase of the process, was the feeling of intellectual and emotional fellowship, confidence and self-assurance;

's'/../ The sense of community is a strength...You learn more about your self through the tutoring...It's not only the patient..it is what I have difficulties with, or what I am good at...I learn about my strengths and weaknesses...

The researchers' interpretation is that this phase of the process was important for reflection and change in perspectives of the professional role. The participants' descriptions show that prevailing conceptions of the problems were both challenged and confirmed through the varied perspectives that the participants brought to the group.

III. Getting accustomed: Learning the language

After spending some time and getting used to the culture in the new country, the traveller gradually feels more secure and starts to act more confidently, actively experimenting to apply what has been learnt.. The themes "daring to ask that question" and "feeling more honest" portray how the BGT participants, with a growing self-confidence applied the new knowledge that they had achieved through the group training in clinical practice.

[&]quot;Daring to ask that question"

This theme refers to the participants' experiences of what happened after the Balint group sessions, when they returned to clinical work with their new knowledge and experiences. The researchers' interpretation is that the participants felt confident to address the problem more directly in complex situations. One of the participants described this as follows:

's'/../ I think I have become a bit more sensitive, both to my own reactions, to the patient encounter and the patient's reactions..How they say things, what they do and how they react...I think I have become a little bit more humble and thoughtful...I think I dare a little bit more, maybe to ask that difficult question that felt frightening..

The subjects' descriptions also show that the experiences of participating in Balint training also affected the handling of difficult patients and the framing of the series of treatments as a whole. It seemed to be easier to be clear, to set clear frames regarding appointments, expectations and treatment.

's'/../ To be more clear and firm about the frames for the treatment..I think that with help of what I've learnt from the training, it actually leads more directly to the core of the problem.

"Feeling more honest"

The participants described their experiences of difficult situations as a feeling of dishonesty towards the patients in cases where the therapists were aware of their inability to deal with the complexity of the patient's problem. The therapists avoided the difficulties in these cases by treating what was most visible, namely the physical symptoms, even though they

intuitively realised that there was something more to it. The participants described how the Balint training helped them to develop a more open relationship with the patient, as commented on below.

's'/../ I am feeling more honest towards the patient, instead of just standing there, giving treatment, and at the same time thinking: there is more to this problem than just the physical symptoms..

IV. Coming home: Seeing the landscape differently

Returning from a journey often means the start of a new process of comparison. Familiar things may look different when connected to and compared with experiences from another context, as referred to in the theme "seeing what is me and what is the patient". The theme "I don't think that you ever learn enough" portrays how the experiences lead to further reflections on the personal and professional role, and made the participants see their professional landscape and the needs of continuous learning in a different way.

"Seeing what is me and what is the patient"

The participants described how the training helped them to become aware of the boundaries of their own person and their professional role and also helped them to understand the patients more clearly. The discussions in the group could be interpreted as a way of learning and understanding that illuminates and articulates the clinical processes;

's'/../ When I have brought a patient problem to the group, we have discussed it and sometimes played a role play, where one of the other

participants played my role and I played the patient's role...And I noticed, that she reacted in the same way as I did, with anger and irritation... /../ And we could discuss; what was it about that patient that evoked those feelings...I learned a lot from that...Maybe it wasn't because of the patient, and maybe not because of me either...So much happens in the encounter between two people..

There were also some reflections that indicated that the participating physiotherapists had come to challenge their previous conceptions of the professional role;

's'/../ Sometimes I think that health professionals tend to preserve and reinforce pain instead of relieving ...by the way, we are...instead of reinforcing the patient's strengths, we emphasise the illness, and might well preserve it through our endless treatments...Maybe that is not what we should do, maybe we should try to support and elicit the patient's own energies, powers and defences...And maybe we should do it differently, not in the traditional physiotherapeutic way....

"I don't think that you ever learn enough"

The heading points to the process nature of learning through BGT, achieved through the continuous choice of cases and problems from clinical reality. This is described as an ongoing process in which the participants shaped their learning together and subsequently applied their knowledge in clinical practice;

's'/../ I think this is valuable and that it gives a lot to you as a clinical practitioner...I mean, that you never end, you keep on, and reflect on what is happening and what you're doing..

At the same time, the process in the group was not always easy for the participants. Sharing your experiences with others who have been invited to reflect on your thinking and acting also means that your professionalism is questioned, and this requires a group climate that is characterised by confidence. Two group members described this as:

's'/../ You are pretty...naked, in a way...so we have to be tactful..Gentle encounters...It has to be, if there is going to be any quality to it...Otherwise.. I don't know what to say.../../ Because this is all about deepening yourself emotionally in a way...and then you are vulnerable...So we have to be tactful...

DISCUSSION

The Balint group training could be said to provide the participants with an opportunity to learn through reflection, since the actions and interactions in the patient encounter were continuously questioned and discussed in the group. The process could also be described as an experiential learning cycle (Kolb, 1984), the participants moving from phases of concrete experiences and reflective observations over to abstract conceptualisation and active experimentation. The participants proceeded from the experiences of unique cases from clinical practice, to a more general level of knowledge, where alternative interpretations and choices of actions seemed to enrich the participants' understanding of the situation. The results give a very positive image of how the process was conceived. A larger number of informants might have provided a more diverse picture. On the other hand, the results of a qualitative analysis are not generalisable in terms of generalising frequencies of occurrence of different subgroups within a population. The issue whether the results of a qualitative analysis are generalisable to other contexts is, instead, a question of rhetorical qualities of the text. The results are generalisable if the reader could, with the description of the experiences within this particular context in mind; come to think of and understand similar processes in other contexts (Larsson, 1994). Another question is whether the researcher's interpretations really reflect the interviewee's experiences. Kvale (1996) claims that the issue of validity in qualitative research is not about correspondence with an objective reality, but rather a question of whether the interpretations are defensible. In this study, the analysis was carried out by three researchers in several steps, first separately and then together, cross-checking the data and questioning our preliminary descriptions, aiming to achieve a reliable interpretation through inter-subjective consent.

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The Balint group process could possibly contribute to articulating tacit

dimensions of the physiotherapists' professional knowledge and to

enhancing the participants' "practical theory" of their professional practice.

Handal and Lauvås (1987) describe the concept "practical theory" with

respect to professional knowledge in teaching - they argue that all teachers

have an integrated system of knowledge, experience and values as a result

of previous experience and learning. This system is a personal construct

developed individually through a series of varied experiences of

professional work. The practical theory could be developed through peer

tutoring, and lead to a better understanding of the teacher's own resources

and how these resources can be applied to benefit student learning. It is

reasonable to assume that this line of argument is also valid for

physiotherapists. Our conclusion is that BGT and sharing the experiences

of others could be considered a way of enhancing the understanding of the

patient encounter in clinical practice, a journey "to Paris to learn more

about London", which could benefit both physiotherapists and their

patients.

Word count: 4 742

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