TO INTERVENE OR NOT INTERVENE, THAT IS THE QUESTION*

Paper presentation

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Abstract

Deciding when and how to intervene in a Balint group as a Balint group leader is often complex and at times difficult to teach. Interventions determine not only the frame of a Balint group but also the safety and richness of the content and learning. This paper will discuss what can be called “non-discretionary” interventions that need to be made in order to

make a Balint group a Balint group, “discretionary” interventions that lead to increased understanding of the case but may for various reasons go unspoken, and a process for how a leader might make a decision to intervene.

I have noticed over time that many interventions that occur to me while leading a Balint group go unspoken. This has led me to try to delineate my basis for choosing to make an intervention and what my cognitive process is when a possible intervention occurs to me. How well thought out is this process and why is it that some interventions just feel right? In this presentation, I will examine these questions.

In 2006 Marian Lustig and I wrote about how Balint groups help integrate intuition and reasoning in medical decision making building on Daniel Kahneman’s work (Lichtenstein and Lustig 2006). Kahneman (2003) described two cognitive systems that operate with decision

making: system 1, or *intuition*; and system 2, or *reasoning*. Intuition is fast, parallel, automatic, effortless, associative, and emotional. Whereas reasoning is slow, serial, controlled, effortful, rule-governed, flexible, and neutral. With experience, proficiency, and increasing mastery, care providers, and Balint leaders, can begin to use automatic intuitive processes to make decisions. This presentation will incorporate this way of viewing decision making into understanding Balint leadership.

Leading a Balint group requires multitasking: listening to the case content while monitoring and directing group process, tracking time, tracking group development, and monitoring one's own emotional reactions, to name some of the tasks (Johnson et al 2004).

Over time, and with experience, some of this becomes an automatic, intuitive process which allows interventions to bubble up. There are times when I can articulate the rationale for an intervention – sometimes in real time, sometimes after they are in my head demanding to be released. Since the group is happening in real time, there is time pressure

to decide whether to intervene or not. Not all interventions will or should be spoken. Given the time pressure and complexity, an accurate intuitive, automatic system can help. However, when an intervention pops into my head do I trust my intuition and judgment or don't I?

I have begun to categorize interventions as either non-discretionary or discretionary. In my training in the American Balint culture I would classify non-discretionary interventions as those that are necessary to promote basic group functioning. If these interventions are not made, the group process will suffer and the group may not feel adequately held by the leaders. Examples are those interventions listed below that maintain basic group structure, frame, and safety.

With your indulgence I would like to insert a bit that is not in the proceedings. I realized when I was making the slides that I should have listed the non-discretionary elements in a slightly different order.

Starting and running a Balint group is a bit like building a building. The frame and setting are like the foundation. That should have been listed first. Ideally, we have a private, confidential space. If we are running

the group in an institution, we have the institutions support. We would generally not want to run a Balint group in a busy market or cafeteria. There should be minimal outside interruptions.

Once we have that foundational space, we can build the Balint structure. After the foundational frame and Balint structure we can work toward maintaining safety so that group members can feel free to present cases. So I would like to present what I think of as non-discretionary interventions in that order.

Keeping the frame (a protected space)

- Starting and ending the group on time
- Keeping intrusions out
- Redirecting tangents to their relevance to the case
- Keeping to one case and presenter's viewpoint if multiple group members know the patient

Most all structural interventions (when using push back)

- Calling for the case
- Asking for questions of fact and limiting the questions to facts
- Suggesting the presenter rest
- Inviting the group to ‘take’ the case
- Providing enough time for the group to discuss the case
- Bringing the presenter back in
- Ending the group

Safety

- Limiting critical questioning or comments
- Limiting group members pushing others, especially the presenter for self- disclosure
- Limiting focus on the presenter’s psychological dynamics

Helping group members take responsibility for their own thoughts and feelings

With some “non-discretionary” interventions it is clear from the structure of the Balint method, or architecture as Sternlieb (2011) called it, that it is the role of the leader to direct the group process. With other “non-discretionary” interventions when the frame or group safety is in danger of being violated, a Balint red light goes off and the need for intervention is clear. Intuitive, automatic reactions serve well in those situations. The primary caveat is thinking about how to phrase those interventions in order not to shame a member or the group. With practice that also becomes more automatic.

Discretionary interventions are interventions that enrich the group’s understanding of the case, emotional reactions, and relationship issues. The group will function simply fine without these interventions, but the depth of understanding might suffer. Examples of reasons for discretionary interventions are as follows:

Balancing representation of the provider and patient

Commenting on the emotional tenor of the case or group discussion

Reminding the group about the presenter's dilemma and words in the presentation to focus the group

Highlighting metaphors

Deciding whether to allow for colleague or supervisor relationships as the central element of a case

Breaking or allowing silence

Balancing participation by group members

"Discretionary" interventions may, or may not, optimize the richness and understanding that comes from the case presentation and discussion., Klein (2003) describes intuitive functioning as depending on accurate pattern recognition. Data is perceived from multiple inputs in a holistic format which leads to the ability to make rapid judgments. However, a range of variables increase the salience of information used

for intuitive judgments, not the least of which are 'hot' states of high emotional and motivational arousal (Kahneman 2003). How do I know if my thinking is a product of the case and the needs of the group or my own emotional reaction coming from somewhere else?

To function optimally, a Balint leader needs to be sufficiently self-aware to monitor use of the intuitive system, have some sense when emotional reactions are playing a part in the situation, and to know when to slow down and effectively bring the reasoning system into action. Novack et al (1999) called this 'reflection-in-action'.

When an intervention comes into consciousness, hopefully it brings the reasoning system to the fore. Ideally the function of the reasoning system is to monitor the use of intuition and deliberately override a quick, typically used but inaccurate response. However, the corrective operations of the 'reasoning system' may be impaired by such factors as time pressure, concurrent involvement in a different cognitive task,

'morning people' performing the task in the evening, 'evening people' performing the task in the morning, or even by being in a good mood.

Since it is certainly quite possible for a well functioning group to have a fruitful group with minimal intervention, as I consider this dilemma, I have certain questions somewhere in mind that help determine whether to make a discretionary intervention.

> Is the group working well without me?
> Does the group need to develop a sense of its own agency?
> How important is the intervention to the understanding of the case?
> Is the intervention for me or for the group?
> Early in the group – will the group get there on its own?
> Late in the group – is there time for the group to change focus?

> Is one member so totally dominating or the group using that member to the detriment of process?
>
> Will a group member relate some introduction of personal information or another case to the case presented?
>
> Does a little advice giving from a member help that group member get involved?
>
> Is this silence helpful or not?
>
> Has enough time elapsed for my co-leader's intervention to have played out?
>
> Is support with calm presence enough or does the group need more?

When I think of an intervention, I cannot say I go through those questions systematically. The consideration of those questions has become relatively automatic. I usually repeat the intervention to myself a couple of times to see how it sounds and whether it makes sense. Borrell-Carrio et al (2004) describe the process of diagnosis and

treatment as creating a clinical tension which is heightened by uncertainty and relieved with the acceptance of a diagnosis and plan. This tension can be difficult to live with and lead to premature closure or over reliance on intuitive automatic processes. Even though I feel less anxious leading a Balint group than I did early on, it is common when I lead Balint groups to feel the same tension with uncertainty. Hopefully, the uncertainty is helpful in calling on the reasoning system if it is not paralyzing.

Here is a case example that illustrates a number of leader processes I have identified in this paper.

A member of our Balint group presented a case of a patient she saw in training years ago. The memory of the patient had stayed with her. The patient had died by suicide sometime after the presenter had moved on in training and stopped seeing them. The relationship had been a good one and the patient had seemed to be improving.

We were using the pushback method in this group and all the non-discretionary structural interventions such as asking for a case, asking for clarifying questions, pushing the presenter back, and bringing them back in were all used.

Several discretionary interventions occurred to me around the themes of abandonment, guilt, and boundaries. I made one early intervention "Why does this patient stick with us" in hopes of getting to some of those issues. The group responded to that intervention with the pain and responsibility that might be felt. I had thought of the intervention "Why is this patient always punctual and showing up to clinic often?" The group discussed this without my input. That indicated to me that at least I was tracking the group reasonably well. Later in the group it occurred to me that the presenter was probably the same age as the patient's daughter. I decided it was too late in the group to get to that and in the remaining moments the group went back to a sense of guilt, remorse, fear for such patients, which was more useful than my intervention might have been at that point given that the group continued to work

actively and to deal with genuine feelings. That proved to me once again that sometimes a non-intervention is the best one.

In the case cited above my co-leader and I discussed many of the unspoken interventions in the debrief in the hopes of learning from them. In fact, we thought of interventions that might have been brilliant had we actually thought of them in real time. Something that seems to happen quite frequently.

As in other tasks, the more experience one gets as a Balint leader, the more comfortable one becomes with trusting one's intuition. Preparing this presentation has helped me to gain some understanding about the mystery of why an unspoken leader intervention is never spoken. Over the past 30 years of leading Balint groups I have come to trust my intuition and go with it a fair amount. After all, the group can choose to ignore an intervention if it does not fit or come back to the intervention when they are ready. Very few interventions are damaging to the group unless they are mean spirited or shaming, or repeatedly over-controlling.

I have come to feel the necessity of intervening in non-discretionary situations, and the virtue of questioning whether to intervene in situations that I believe are discretionary. Hopefully, I get it right. And if not, my co-leader is sure to let me know.

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