Using Balint groups to aid hospital providers during the COVID-19 outbreak

Damir Huremović, MD, MPP, FAPA, FACLP, Director, Psychiatry, North Shore University Hospital, Manhasset, NY, USA; Northwell Health, Inc. Submitted March 29, 2020.

There is little known data about the psychological effects that pandemic outbreaks can have on frontline healthcare personnel, simple because the last relevant pandemic took place a hundred years ago. There are some small studies stemming from the SARS outbreak and subsequent outbreaks that indicate that north of 10 percent of direct providers have symptoms of traumatic stress, a figure that is amplified by experiencing quarantine and/or isolation.

Planning ahead, we were wondering if we could put something together in order to provide early and ongoing support to our non-psychiatric colleagues as they battle this pandemic. We have identified two avenues of action.

One avenue was emphasizing with the hospital leadership the need for clear guidelines, open channels of communication, and appropriate logistical support. These are non-psychological interventions, really common-sense interventions, that go a long way towards preventing emotional trauma associated with the outbreak.

The second avenue was to design an *ad hoc* program for delivering emotional support to our frontline colleagues in a direct manner. We have identified a window of opportunity that opens right before the onslaught of the outbreak and stays open through the its early stages. This opportunity arises from the fact that, going into the outbreak, hospitals activate their contingency plans and their Hospital Incident Command System levels. This allows them to reduce the number of inpatients and prepare beds for the influx of COVID-19 affected patients. Reduction of inpatients most likely leads to a decrease of inpatient consults. Furthermore, a significant portion of COVID-19 patients during the first wave are admitted to ICUs requiring intubation and are not initially seen by C-L psychiatrist in great numbers. Additionally, an overarching philosophy of reducing unnecessary exposure will lead to a further temporary decline in consults.

Such developments may free up resources of C-L psychiatry services and give them an opportunity to:

1. Setup their contingency plans, including staffing adjustments and telepsychiatry modality implementation, and to
2. Advance their liaison work and put in place processes to address the emotional needs of the general staff arising from the advancing outbreak.

There are no firm or clear guidelines on this process and it may require trial and error until the right approach is identified. One way of implementing this work with non-psychiatric personnel is through reviving/repurposing Balint groups.

Balint groups have originated in the 1960s, as a form of purposeful, regular meeting among practitioners (originally family physicians), with a trained facilitator or leader, to allow discussion of any topic that occupies a physician's mind outside of his or her usual clinical encounters. They have been used for decades as an opportunity for medicine practitioners to present clinical cases to psychiatrists in order to better understand and to improve the clinician-patient relationship. Those groups traditionally focus on enhancing the clinician's ability to connect with and care for the patient sustainably.

A Balint group has between 6 and 10 members, with 1 or 2 facilitators or leaders. The format of a Balint group is a case presentation (from memory) for about 3 to 5 minutes and a discussion for 1 hour or more. The immediate benefit for participants is to have a safe place where doctors can talk about interpersonal aspects of their work with patients. Gradually, participants may reach a deeper level of understanding of both their patients' feelings and their own.

In their new iteration, Balint groups are envisioned as virtual or hybrid encounters, relying on software that allows multiple video streams (e.g., Zoom, but even Skype can suffice). In those encounters, physicians have the opportunity to present challenging cases in order to better understand their relationship with and improve their alliance with the patient, ultimately improving both outcome and practitioner's satisfaction at work.

In addition to using virtual sessions, there are a few more modifications to the process:

1. Utilizing groups where practitioners discuss their own anxieties associated with the pandemic and its effects on patients in general, not necessarily focusing on an individual patient. If there is an information gap between what is known about the illness and the ways to combat it, the gap will generate significant anxiety and distress among providers. And there are gaps – just think of a lack of tests leaving uncertainty very much in the game, or a lack of PPE leaving providers feeling exposed and let down. In this aspect, the group works as a process group for coping with stress and, likely, trauma.
2. Focusing on the isolation and despair identified in the parallel process reflected in the provider patient and provider community relationships. This becomes a central point in the supportive workload for frontline providers, as they seek to diminish the isolation, abandonment, and despair of the patient. At the same time the practitioners may find themselves isolated and abandoned by everyone else, left to their own devices while struggle to provide basic medical care. Reports from Italy indicate that the total isolation of their patients was among the most traumatic experiences for providers. Patients were sequestered on arrival, sequestered in isolation where many died gasping for air or suffering a cascade of multiorgan failure, and sequestered in their deaths, possibly cremated and/or buried without their families' presence. Such sequences of events were unfathomable to frontline providers and deeply traumatizing. Overcoming the sense of isolation and abandonment, dispelling despair, and instilling reasonable hope becomes a cardinal task for the mental health professional in the group, with the aim of empowering practitioners to continue to do so for their patients and their families.

At this time, we are experimenting with the timing, duration, and frequency of those sessions as well as the format and the participants. We have 30-45 minute sessions in mind, once or twice weekly, for different providers: ED and ICU physicians, anesthesiologists, nurses, and advanced care providers (PAs, NPs, Respiratory therapists) who expressed interest. We are involving our residents in this endeavor. In any case, we argue that doing even a couple of such quick sessions may have lasting effects in breaking the walls of isolation, or even better, preempting them.

In their initial groups, participants (ED attending staff) seemed more preoccupied with their organizational challenges, rather than with experiences with individual patients. They wanted to talk about the challenges of setting up the ED for each shift, trying to negotiate the needs of various services and failing to attain mastery in this aspect of their work that never represented an unsurmountable challenge before. My impression is that there is a pervasive sense of impotence and helplessness among our colleagues; their focus on processes and logistics, rather than on experiences with patients or their own emotions, is a way to wrestle back some of the sense of control that has been snatched away from them.

They also talked about their communications with colleagues from other countries, mostly Italy. They seem to be aware of the enormity of the situation and what lies ahead, so there is a palpable sense of dread. So far, we allowed participants to pick what they want to focus on and we will be cautious with corralling the direction of the session or providing feedback.

Residents and residency programs from other specialties have expressed their interest in exploring this forum and we will be starting resident groups next week. Other segments of our health system have opted for more traditional support groups (including virtual drop-in sessions) and it will be interesting to compare notes as this situation develops.

In either approach, the goal of such sessions is not to address the individual psychopathology of participants or to provide full posttraumatic stress care. If such individuals are identified, they will be referred to a more focused individual mental health care if they agree. At our facility, we maintain contact with the Employee Assistance Program (EAP) that stands ready to provide more individualized care.

The author denies any conflict of interest related to this submission.

References:

1. Lu YC, Shu BC, Chang YY, Lung FW. The mental health of hospital workers dealing with severe acute respiratory syndrome. Psychother Psychosom. 2006;75(6):370–5.
2. Lung FW, Lu YC, Chang YY, Shu BC. Mental symptoms in different health professionals during the SARS attack: a follow-up study. Psychiatry Q. 2009;80(2):107–16. https://doi.org/10.1007/s11126-009-9095-5. Epub 2009 Feb 27

3. Mak IW, Chu CM, Pan PC, Yiu MG, Chan VL. Long-term psychiatric morbidities among SARS survivors. Gen Hosp Psychiatry. 2009;31(4):318–26. https://doi.org/10.1016/j.genhosppsych. 2009.03.001. Epub 2009 Apr 15
4. Roberts M. (2012). Balint groups: a tool for personal and professional resilience. *Canadian family physician Medecin de famille canadien*, *58*(3), 245–247
5. Salinsky, J. (2009). A Very Short Introduction to Balint Groups, The Balint Society website https://balint.co.uk/about/introduction/
6. Huremović D. (2019) Quarantine and Isolation: Effects on Healthcare Workers. In: Huremović D. (eds) Psychiatry of Pandemics. Springer, Cham. DOI https://doi.org/10.1007/978-3-030-15346-5_10