Converting The Stress Of Medical Practice To Personal And Professional Growth: 5 Years Of Experience With A Psychodynamic Support And Supervision Group

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Abstract: **Medical practice is stressful. Although much of the burden comes from the content of the work, physicians' personalities and emotions contribute greatly. Few traditions or structures are available in the medical community to help physicians deal with this stress and prevent disillusionment and impairment. This article describes the 5-year evolution of a physician-support group that has provided supervision and psychodynamic insight. The key elements of the group's effectiveness are leadership, connecting work issues to personal dynamics, defusing defenses, and ensuring confidentiality. Competitiveness, mistakes, anger, difficult patients, death, fear of malpractice, and family-work tensions are issues that have been addressed. Psychodynamic supervision groups differ from peer-support groups and therapy groups. Psychodynamic supervision in support groups, as used in the supervision and training of pastoral counselors, offers a simple and powerful means to ease the burdens of medical practice and thus prevents disillusionment and subsequent impairment among physicians. (J Am Board Fam Pract 1991; 4:151-8.)**

In 1984, 7 primary care physicians formed a support group to deal with issues of work stress. This report details the process of forming the group and its evolution from an initial focus on difficult clinical cases to one that examines relationships—personal, marital, and professional. We found that to address the sources of physician stress, promote personal growth, and prevent disillusionment and dysfunction, we had to blur the margins of psychodynamic theory, supportive therapy, and clinical psychological supervision. This paper relates personal experience and is thus anecdotal and idiosyncratic. Groups such as ours do not necessarily provide a general solution to the problem of physician stress and dysfunction; however, we hope that a description of our intensive effort can provide insight into the sources and character of stress in medical practice and how to deal with it.

Stress in Medical Practice

Physicians are subject to much stress,[1,2] high workloads and long hours,[3] feeling great responsibility for their actions,[4] and a high level of job complexity.[5] It has been suggested that the same compulsive personality traits that get most physicians into and through medical school and residency might be one cause of their subsequent disenchantment and depression.[6,7] A longitudinal study of Harvard medical graduates by Vaillant, et al.[8] suggests that pre-existing personality traits, particularly dependency and compulsiveness, generate much of the stress, especially in primary care, causing many physicians to feel overwhelmed, helpless, or overworked and to blame others for their problems.[9-13]

Most medical communities have not developed effective means to prevent the everyday stress of medical practice and only recently have addressed the late effects of stress—frank impairment.[14] Our experience leads us to propose that peer support groups designed to integrate clinical supervision and personal psychodynamic insight can offer medical communities an effective approach to prevent disillusionment and dysfunction through stress reduction. Such a model is used to train and support pastoral counselors and the clergy.[15] We believe it is appropriate to adopt this model for physicians because practicing medicine has distinct parallels to ministering, and the stress of both professions comes from similar sources—the connexional, existential, spiritual, and psychodynamic.

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Groups in Medical Practice

Influenced by psychoanalytic practice in the 1950s, Michael Balint organized groups of British general practitioners to focus on the physician-patient relationship. His classic book, *The Doctor, His Patient, and the Illness*,[16] reports this original work and has provided a structural basis for many Balint groups throughout the world.[17] In the United States, however, such psychoanalytical groups have not been used extensively in training primary care physicians. Despite the lack of such specific training, it is a widespread, if unsubstantiated, belief within family practice, internal medicine, and pediatrics that residency-trained physicians are a psychodynamically sophisticated group, possessing the knowledge, skills, and maturity to address the psychological aspects of patients, medical practice, and illness.[18] Stein[19] challenges this perception by detailing prevalent dysfunctional and unconscious factors within physicians (countertransference) and within most physician-patient relationships.

In recent years, support groups that generally focus on transactional psychology, professionalization, and institutionalized roles have been developed for residents, medical students, and nursing staff.[20-22] Programs for impaired physicians have also been developed, usually involving individual psychotherapy.[23] All these groups and treatments are aimed at specific populations and issues that, while they overlap with the world of primary care physicians, are not sufficiently concordant to deal adequately with the stress of everyday practice. Peer groups for practicing physicians have been described,[24] but the structure, process, and goals necessary to provide effective support have not been defined specifically.

Structure of Our Group

For the past 5 years, a group of primary care physicians has met weekly in our community hospital. Our initial goal was to improve our understanding of the practice of medicine and to reduce the stress of patient care. Members wanted help in facing the psychological, political, and economic challenges of daily medical practice in order to avoid the disillusionment believed to be prevalent among older physicians. Over the years, the focus of the group has evolved from discussions of patient care to explorations of personal values and feelings, approaching the practice of medicine through its human components: dying, fear, anger, intimacy, competition, mistakes, competence, and separation-individuation. We see our stress as deriving from the difficulty of facing these issues, particularly in the context of doing healing work. In the process, we have experienced the validity of an original Balint group member's comment: "The concept that there is a professional ego suitable for training and a personal ego to be left alone . . . (wears thin); there is really only one ego."[25]

From the first, a professional leader's presence has been crucial. Our leader has contributed discipline and insight, as well as a skilled confrontation technique that stimulates the group interaction to exceed the usually gentle, often uncritical, support of a peer group. Our financial commitment is modest but important. Our leader is paid $100 each hour. Uneasy about stepping into this uncharted world, we agreed to call this group educational and do not bill any insurance companies for group therapy.

Our group leader has a doctor of ministry degree in pastoral counseling, which is a clinical degree with strong emphasis on group and psychodynamic training. As a former supervisor with the Association of Clinical Pastoral Education, he has provided group and individual supervision for the clergy in general and for staff at mental hospitals. He has also experienced his own personal psychotherapy, a requirement for certification by the American Association of Pastoral Counseling, based on the assumption that all persons in the profession have unresolved personal issues and conflicts that need to be addressed for them to function optimally as therapists.

Our group has 10 members. The 7 original members are all residency-trained family physicians who were aged 27 to 37 years when the group began. Three members have been added in the past 2 years, another family physician and 2 internists, who joined the group after working separately on personal issues. The group has 2 women, all members are married (we have one married couple), everyone has children, and one member is older than 50 years. Three family practice groups are represented, dividing the family physicians into partner subgroups of 3, 3, and 2. All members are in fee-for-service private prac-

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tice. Religious affiliations of the group members are varied and have been an important issue within the group for only 2 members; 3 are Unitarian, 2 are Catholic, 2 are Jewish, and 3 are Protestant.

Leader's Comments

The participants seem especially sensitive and caring about people. They are attentive to human values, such as relieving human suffering and fostering psychological integration and satisfaction for individuals and families, in addition to being interested in the physical health of their patients. Two members originally studied to be Roman Catholic priests. A number have been active with the local chapter of Physicians for Social Responsibility. Several have had experience with similar groups in residency, so they know the value of such a group. Others have benefited from psychotherapy or marital therapy and are positively oriented toward psychological growth processes.

Though church-based clergy are familiar with clinically trained pastoral counselors who practice as independent psychotherapists, it is understandable that many physicians are not and would, therefore, be puzzled by the idea of a pastoral counselor providing leadership for a physicians' group. There are two national clinical training accreditation programs for clergy. Under the Association for Clinical Pastoral Education, clinical pastoral education (CPE) programs are offered to divinity students, who take up to a full year's internship, usually in a general or mental hospital, where they function as pastoral counselors to the patients. Interactions with patients are analyzed in daily seminars, with particular attention paid to countertransference issues. An additional daily group-dynamic meeting, along with weekly consultations with a clinically trained supervisor, provides further opportunities for exploring and resolving countertransference issues. CPE supervisors go through an intensive accreditation process, part of which involves months of daily group-dynamics participation and leadership.

Alternatively, a pastoral counselor in independent practice can be a Fellow or Diplomate of the American Association of Pastoral Counselors. To achieve this accreditation, a pastoral counselor must hold a Doctor of Ministry specializing in counseling and must have completed 6 months of a CPE program and obtained sufficient psychotherapeutic help as a patient to convince a committee of peers that his or her emotional conflicts or religious biases have been sufficiently addressed to minimize any negative influence when functioning as a therapist. For both accrediting agencies, experience and training in group processes and confrontation of one's own intrapsychic and interpersonal processes are required.

Inception of the Group

The group began in fall 1984, after one member, hoping to form a Balint group, approached 25 members of the medical staff at our community hospital. All who expressed interest were invited to an initial meeting. Seven residency-trained family physicians attended. Before the initial meeting, the group organizer recruited a therapist experienced in leading groups, who agreed to supervise the group's efforts.

At the first meeting we agreed to set aside 1 hour each week when all physicians were at the hospital (8–9 A.M. Mondays) to present and discuss "tough" cases that, because of their psychodynamic complexity, were not adequately addressed by the texts and consultants. At this meeting, we stated our reasons for attending. Our responses are paraphrased as follows:

1. "My alcoholic and drug-using patients really get to me. I don't know what to do with them."
2. "I used to think that illness was due to diseases of organs, but most of my hospital admissions lately seem more related to family or coping problems."
3. "I'm taking care of a person who is dying and really don't know how to act."
4. "I'm intimidated by partners and colleagues, who have it together and seem so competent."
5. "I don't want to become a burned-out physician when I'm 55 years old."
6. "I don't feel like I'm in control of my practice; this isn't the way I thought it would be."

In retrospect, we are fortunate our group recognized that a professional leader was crucial to our goals, and we did not rely on our own self-perceived psychological skills. We were even more fortunate to retain a therapist who was not only familiar with the connexional, spiritual, and philosophical side of caring for people but also was experienced both in psychodynamic group therapy and educational and supervision groups.

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Leader's Comments

That I came from a town 30 miles away and thus was not influenced by any professional, personal, or political involvements with the group members helped bring about a good match. The primary mental health workers used by most of these physicians were certified pastoral counselors, and I benefited from the positive expectation created by my colleagues.

I was asked to read Balint's book as an intellectual introduction to the world of physicians meeting weekly with a therapist. Although our group went beyond the boundaries of a Balint group, the book was useful in helping me cope with both the physicians' and my own anxieties at beginning something new.

Though years of leading weekly therapy and supervisory groups made me confident of my abilities, several factors initially caused me stress:

1. *As one not trained in medicine, I idealized physicians and was in some awe of them, an experience common to many in our society.*
2. *This specific group fed my idealization; they were all bright, conscientious, and articulate. Such characteristics had never been universal in any of my previous groups.*
3. *My role was originally defined as supervisory and consultative. I am comfortable in that role with fellow clergy. Physicians, however, naturally have a shared background, experience, and calling quite different from mine. As a result, for the first several months the physicians spoke mostly with one another, sometimes in "medicalese," and I faced doubts about what I could contribute. Eventually, however, it was clear that though they had considerable ego strength, they also had strong intellectual defenses, and I could address these defenses.*

Group Evolution

Our meetings for the first year were formal, with careful selection of comments and an intellectual approach to emotional and psychosocial problems. One member would present a problem case each week unless an emergency case took precedence. These early presentations, which centered on chronic pain, substance abuse, sexually attractive patients, somatizing patients, and conflict with consultants, were met with critiques of interpersonal dynamics and clinical feedback. This process allowed members to gain the mutual respect and trust that has been basic to our subsequent work together. During this first year, confidentiality rules were worked out, and the question of sharing our discussions with our spouses was addressed. The complex, intertwined social and professional relationships that are found in small-city lives led us to choose a rigorous level of confidentiality. Although by excluding our spouses from the details of our group experiences, we lost the benefit of their perspective and insights, this confidentiality has allowed us to relate our personal lives to our work, and the group discussed marriage, sexuality, social relationships, and feelings without fear.

After almost 2 years of discussing patients, we gradually began to focus directly on each member's feelings, reactions, and interpersonal dynamics, whether generated by a patient or by family or personal events. It became apparent that our problems with patients had roots in our personalities and experiences extending beyond the immediate practice setting. Initially, group feedback was flavored with more personal anecdotes as we drew from our own marriages, relationships with our own parents and children, and memories of our own upbringing. The turning point was a deeply personal presentation of a terminally ill patient that evoked the presenter's own fear of death. Feelings have gradually replaced intellectualization as we find the issues critical to our professional performance to be related more to our own marital discords, fears of death, failures to live up to our goals as parents and persons, and feelings of incompetence or uncertain self-esteem. In essence, to reduce stress and do our clinical work well, we find that we must deal with our own unfinished business with parents and childhood raised by the day-to-day work of patient care.

An opening and closing format adopted in the past year encourages personal statements. Each participant begins by sharing his or her current concerns and goal for the day's meeting, and then we pursue the most interesting or urgent agenda. We conclude with each participant giving a brief critique of the meeting. As issues of important emotional content have become predominant, the group plays an ever greater role in stabilizing members' personal lives. Personal insight and support have become instrumental in moving us toward our original goals of strengthening our work, improving our ability to deal with difficult

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patients, and turning the stress of practice from a burden into a stimulus for personal growth.

Tracing the flow of the previously mentioned member's insights since his presentation of the dying patient 3 years ago highlights the interplay of personal insight and professional performance. After he became aware that his urge to allay fear of death in others was so strong because his father constantly used threats of dying to control emotions, this member became aware of a previously unconscious anger that affected his physician-patient, colleague, and family relationships. He then explored his thoughts about religion and altruism and his ambivalence about them. Discussion about an argument with a partner over reimbursement schemes led to further insight about using intellectualization to avoid intimacy and unpleasant emotions. Recently, talking about unruly children, childhood fears, and a distanced brother has added insight and more openness. Today, his work, made up mostly of relationships, is perceived as a manageable source of meaningful encounters, not as a trap or an overwhelming burden. His discussions of patients, family, and colleagues are laced less with frustration or projection and more with understanding and compassion.

In spring 1987, a respected member of the medical community committed suicide. During the postsuicide presentations made to the medical staff, the ongoing work of our group became known, and a second support group was begun. As our group dealt with the impact of this suicide, it was comforting to realize that the honest feedback and support the group had developed for more than 5 years made us less susceptible to the depression, isolation, anger, and poor judgment that drove our colleague to kill himself. This awareness has greatly strengthened each member's commitment to the group process, and in recent months, we have been able to reach out and add 3 new members.

Leader's Comments

My years of experience conducting group therapy and leading supervisory groups for clergy have been important. Group issues may call for a supervisory role when physician-patient dynamics are involved, group members may require group therapy when interpersonal conflicts between group members need to be addressed, or group members may need direct psychotherapy when an individual member or a member's marriage is troubled.

Although I am a clinically trained pastoral counselor, group therapists from other mental health disciplines can provide leadership for similar groups. The group leader should be skilled in group therapy, individual psychotherapy, and marriage and family therapy. In addition, training and experience in professional supervision are important. There are clinical social workers, clinical psychologists, and psychiatrists who include all of these skills in their repertoire.

Some physicians understandably fear that a pastoral counselor will bring a specific, rigid religious model to healing work. A pastoral counselor who is a Fellow or Diplomate of the American Association of Pastoral Counselors will have examined any religious bias so as not to bring it into therapy or supervision work, and rigidity and proselytizing should not surface. Before hiring the leader, those forming a physicians' group should hold a leader-evaluation interview, which will allow both the group and the leader to assess the appropriateness of their fit to one another.

Support, Supervision, or Therapy?

As this group has moved away from the Balint model of presenting cases, it offers a support system that is different from either classic group therapy or peer support. As the group has evolved, we have come to link our personal emotional health and growth with our professional performance and growth. Our work has brought out the similarities of doctoring and ministering; both are healing work. By applying the clinical pastoral supervision model to our group, we have mixed psychodynamic therapy with supervision and support, placing the physician-patient relationship and the personhood of the physician at the crux of a physician's work. With this approach, the personal issues of working (isolation and competitiveness, judgment, errors, wealth and personal value, limit setting, and relating to partners) and the existential human issues of practice (suffering, loss, and death) become the focus of group work.

This focus has been constructive. We have come to see the work of practicing medicine as caring for people rather than applying technology to disease, and the pastoral counseling approach of psychotherapeutic supervision, combined with focused psychodynamic therapy, has been an effective way to learn to care for people. We under-

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stand the issues of practice and patients by recasting them as the universal issues of being a person and by growing within ourselves.

Economic and social interconnections set limits to exploring some of the more difficult interpersonal and intrapersonal dynamics in the group. Yet, the group trust has become strong enough to allow each at different times to address both partnership and family issues. This experience has been very powerful, because physicians are at risk of substituting stereotyped work relationships for intimacy and family to the detriment of both work and family.[26]

Leader's Comments

Clinical training for pastoral counselors teaches them to face the reality and inevitability of such existential human experiences as suffering, loss, and death as both emotional and intellectual challenges. Dying can be meaningful rather than simply a failure. This approach has proved particularly relevant when working with the physicians in this group. For example, physicians know intellectually that all patients suffer and eventually die, but at an emotional level physicians often experience that reality as their own failure, with accompanying depression and fears. Through group work, it is possible to see that the act of facing death is challenging in itself both for the physicians and patient. When comfortable with their technical skills, physicians can find the process meaningful, not fearful and defeating. The pastoral counselor is trained to see the clergyman and his or her management of the relationship with the patient as the main tools of healing work. Casting medical practice as healing work and accepting the central importance of physicians as persons with various relationships have led the group away from the Balint approach, adding a blend of supportive psychodynamic insight and therapy to clinical psychological supervision. This blended purpose and process have been the key to the group's success.

Conclusion

Our experience is that the stress of medical practice is most understandable on a psychodynamic level. Such understanding requires physicians to bypass their major defenses of intellectualized denial. We have developed a method to alleviate and prevent much stress—support groups using a blend of limited psychodynamic therapy and psychological supervision, an approach adapted from the training model for pastoral counselors. Using this approach requires accepting the parallels of doctoring and ministering and the feasibility of blending techniques in a support group. The advantage of this model is its simplicity in organizing groups. A major difficulty could be the lack of adequately trained, skilled, and experienced leaders.

Our approach to dealing successfully with stress has been validated by the drawing power of the group experience. We are not a unique group or medical community. We are busy, pressured physicians, and free time is rare. Nevertheless, the Monday morning hour has become sacrosanct; our 5-year attendance record is nearly perfect, occasionally even including vacation days. No member has dropped out. In many ways, the group meeting is the highlight of each member's professional week.

The most powerful insight of the group has been to connect the personal to the professional in our lives. Our professional stress and our personalities now seem so clearly linked that it makes sense to process troublesome work issues at the level of our ego defenses and the psychodynamics of our relationships.[24] That the process of strengthening our person strengthens our work should be no surprise because medical practice is an inherently personal task built around relationships and individuals dealing with difficult existential issues—illness, suffering, loneliness, meaninglessness, and death. As self-awareness and comfort with intimacy develop, we apply new understanding and skill to our clinical work.

The relevance of the group experience is best expressed by the following comments of group members in a recent meeting devoted to exploring current activities and goals:

1. "I find myself feeling safer with the people in this room, able to share more of my feelings and personal concerns. This helps work because my problems there are usually over personalities."
2. "I find this the most personal thing I do and the most creative part of my world."
3. "This group provides the intimacy I would like to have throughout my relationships. My only fear is that it doesn't carry over, and the group becomes a substitute for friendships. It has been critical in keeping my group practice

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together by processing potentially destructive issues."

4. "I have felt the issues of motherhood and pregnancy not interesting to others and so have not gotten the support I might have." (This feeling was discussed and connected through the insights of feminist psychology to the role many women have learned of devaluing and discounting themselves. As a result, a new goal of the member and group is to assert feminist issues and increase awareness of sexism.)
5. "I need this time to clarify and express emotions; it's like being in shape, it takes exercise continually. It would be very risky to be this open, though, without a leader. I need this group to keep my emotions straight so I can do my work."
6. "I find this group an emotional reference point. It's the only place to be safe with direct emotional confronting."

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Editorial Comment: Who Cares That The Physician Is A Person, Too?

In the article on psychodynamic support groups for physicians, an important concept is identified: physicians are human, too, and going about one's professional responsibilities takes considerable effort and is often accompanied by some emotional difficulty. Today with the DRGs, RVSs, HMOs, PPOs, CPTs, and ICDs, institutional pressures, third party payors, and governmental and insur-

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