

The Balint heritage

to return, to reconsider, to recover – is it possible?

Dear colleagues,

I have been pondering about what keeps good enough doctors going. Certainly, the joys of doctoring and the wish to make a difference, which we will have confirmed from time to time by our patients. Other, less “obvious and affirmative” aspects are a sense of duty, and a sense of our own belonging to a coherent context and to daily routines.

But these days there is an increasing concern about the deteriorating working conditions for doctors who work in public health services. Many are competent and resourceful colleagues who lead decent private lives but are overburdened by lists of patients which by far exceed what was originally intended. They also carry a heavy administrative burden which often reflects the dysfunctional aspects of public health organizations. These working conditions make them more vulnerable to the secondary traumatization which is inflicted on them by the demands and predicament of some of their patients. I will not bore you with the statistical details which underpin the reality of what I am outlining.

Not surprisingly, given these conditions, certainly not unique to Sweden, it is often argued that Balint group work is directed towards the treatment and/or prevention of burn-out.

Be that as it may. But is this essentially the aim of Balint work? The Balints, while recognizing the general low self-esteem of GPs in their day - were strongly committed to *developing the clinical professionalism* of their group members. Indeed, Michael Balint envisioned that Balint work would increase the morale and self-esteem of the doctor, but it was *not* an explicit aim for the group work. So, what happened to his formula *research with training*?

Is Balint group work always compatible with the external conditions of the practicing doctor? And what about the internal conditions of the doctor? Is Balint work a suitable match for every doctor? How do these issues affect the scope and contents of Balint group work? As a Balint leader, how do you assess whether you have made yourself relevant to a group? What external reality do leaders represent to those joining a group? There may not be generalizable answers to these questions, but nevertheless I think they are important questions to think about, because they highlight the complexity of the Balint project.

As human beings we have a variety of ways of coping with the challenges of daily life. Balint work offers us an opportunity to become more aware of our habitual or repressed reactions and responses,

and how these are triggered in our daily interactions with people – whether they be patients or colleagues. These patterns of reaction are often deeply embedded in our personalities. Doctors in a Balint group are offered space to compare the variety of such reactions between them, and then try to make sense out of them. That may sound simple enough, but the road is usually littered with stumbling blocks and pitfalls. Leaders will have to pay close attention to what is happening in those spaces. The Balints referred both to the inner space of individual members as well as to the mental space of the group.

The frame and scope of Balint group work

The frame and scope of Balint Group work is discussed far too little these days. By that I do not mean the Balint “liturgy” – whether to use push-back or not, whether to be allowed to address the presenter or not etc. I refer to how the Balint leader:

- creates a holding function for the group by his understanding of the motivation and specific difficulties of each individual group member and its impact on the dynamics of the group
- how the leader understands the institutional and general conditions of the working lives of the group members, and
- how the leader manages to articulate and introduce the New Reality of the Balint group, a new way of reflecting on what is going on in the consulting room. This New Reality is embodied in psychoanalytical concepts like resistance, defenses, transference and countertransference, parallel processes, projective identification etc. The Balints showed that it was possible to open spaces for the meaning and understanding of such processes in the doctor-patient-relationship *without* using such meta-psychological vernacular.

The Balints and their followers put much effort into discussing and developing various pathways to achieve these objectives (1, 2, 3). Numerous papers by British Balinters over the years deal with these issues. In fact, the entire Balint Journal constitutes the continuous record of this process. I will only refer to a handful (4, 5, 6, 8, 10, 12, 14)

The shift of aim in Balint work

Within the IBF there is a split, a shift of focus and aim of Balint work:

- from, as Balint phrased, research cum training (i.e. exploration) *to* support
- from professional development *to* maintenance and prevention of burn-out

- from *exploration* of the psychological defenses of the doctor in relation to their patients, to support of the *existing* defensive structures or to various (and sometimes diversionary) educational techniques intended to bring relief
- from *making sense* of feelings and thoughts to staging catharsis through the expression of feelings, or dramatizing scenes or educating group members on how to reach their feelings, at times even educating them how feelings should be expressed “properly” in a Balint group

I tend to think that it depends very much on the individual leader if this split is complete and insurmountable or if there are connecting bridges between these two approaches. Nor can I say for how long this split has existed. It took me some time to become aware of it. But it has certainly been there for quite some time. Frank Dornfest, the President of the IBF in the 1990s in a paper on the standards for leadership training published in 1996 recognized and addressed this potentially problematic issue (7). This also was the vantage point for Andrew Elder and me, when we took the initiative in 2008 to establish a regular IBF Conference on Leadership with its Task Force, which started two years later. The overt purpose was to address these issues.

I would have hoped that the paper by Andrew Elder (5) first presented at the 2016 IBF Warsaw Leadership conference should have initiated a process where the pros and cons of various approaches could be discussed. But few have been catching his bait. A dominating re-action seems to imply that there are many roads leading to Rome. Now, I do not see the value in all roads necessarily leading to Rome, particularly when they do not. There are other cities than Rome full of bustling life and those cities deserve their proper names and recognition. John Salinsky has provided us with a road map to some of them (14), where other varieties of group work for doctors and other professionals are practiced. See also other chapters in the anthology edited by Launer&Summers(11).

Balint was a charismatic teacher, preacher, and an impressive influencer. But to my knowledge he and Enid did not train group members and future leaders systematically and continuously outside of the UK. Maybe enthusiastic Balint proselytes spontaneously adopted new versions which were more attuned to their own educational and cultural background and *their* institutional setting?

Be that as it may, it reflects how external conditions affect group work.

Still, the wonderful atmosphere of international Balint meetings, the sharing of clinical experience with colleagues from all over the world, the mutuality, the long-lasting friendships and eagerness to

welcome colleagues into such a wonderful and inspiring community contain considerable social values. But as much as we treasure and rejoice in these meetings, they may also foster a resistance to inquire into the issues that I am highlighting, a disregard of the vital origins of Balint work.

I think it is important to look back, not for nostalgia, but to see if there is something essential that we have left behind. Can we recover it? Is it possible to make use of it again? The two-year training program for future Balint group leaders that Pia Söderberg, Sonja Holmquist, and I have led jointly, has made us aware of how inspiring, challenging and demanding that project is – for the leaders/teachers/supervisors, but even more so for the trainees.

A Balint group should offer its members the possibility to reflect on their working life from new perspectives *by benevolently challenging both the external and internal realities of its group members*. That is clearly what the Balints and their immediate disciples intended. Enid Balint made it very clear that this is not a quick fix. Normally it takes considerable time to achieve what Balint called “a limited though considerable change” in the doctor. The split mentioned above favours revelatory experiences per se, rather than seeing them in a more time-consuming and demanding “working-through-context”, to make these experiences graft and gradually modify the daily practice of the doctor.

I am certainly not opposing professional groups working with other aims. Any group for lonely and exposed professionals would seem better than no group at all. John Salinsky in his very accessible paper on “*What is so special about Balint groups*” (14), also points out that Balint group work can take place on different levels – bronze, silver, gold. But is the leader capable of facilitating and maintaining work on the higher levels? The Balints and their followers gave much thought to how to implement psychoanalytical understanding in Balint work without excessive use of that lingo (6). Most leaders that came after them were not psychoanalytically trained. Though there were and still are a few contemporary leaders with that background, looking at the British tradition, the main part of new leaders were GPs *well marinated in Balint work on the Salinskyan highest level* (14). But was it enough? It was and is not self-evident to themselves. Reading the essays on leadership by the followers you can feel “the awe of the apprentice”, the respect for the challenge. At the same time their competence and profound understanding of what leadership is about, comes through in their writings! To me this seems like the outcome of a Harmonious Mix-up of thorough training and personal qualities. Do read Michael Courtenay’s brilliant essays (4, 5, 6), and read them over again and again.

Each time you will discover new depths and aspects of Balint work and leadership. In contrast we must ask ourselves, what does it mean to Balint work having a leader who has *not* been well marinated in Balint work on the higher levels? To what extent will that inhibit or even incapacitate the development of group work? Those are challenging questions for self-scrutiny and mutual reflection!

Indeed, co-leadership is an important way to combine the competences required for qualified group leadership i.e psychodynamic, group dynamic, *and* the professional(medical) and institutional understanding of the working life of the group members.

The social, medical, and psychological vicissitudes in Balint work

The Balint group is good for serious and constructive talks on subjects that cannot possibly be discussed in public.

I see the function of the Balint group *primarily* to support doctors in doing their work adequately, in making them the *best possible version of themselves* to their patients.

A good and trusting Balint group allows us to tell uncomfortable truths out of concern and for addressing the resistances and defenses of the group members. Winnicott divided people into avoiders and seekers. I guess that most people are a little of both. But I think that Balint work is designed for doctors with predominantly a seeking – and not an avoiding - inclination. To become more clear-sighted about one's condition does take its time, even if you will experience epiphanies on that long and winding road. In the end, it will promote professional maturity and so the patients will have a better and more trustworthy doctor.

Burn-out prevention seems a likely spin-off effect of such a project – but not its aim.

I never cease to be impressed by the personal qualities and training skills it takes to be a “good enough” doctor in public health. But I am *equally* impressed by a frequent phenomenon, which I am sure that you will recognize it. Colleagues bringing cases to the groups so often are dissatisfied with what they have achieved with their patients. The ensuing group discussion will often reveal that these presenting doctors are confused. They are quite convinced that they have done a bad job, whereas a primarily *non-supportive but respectful and critical scrutiny* to the contrary will reveal that they often have done a decent job, sometimes even outstanding. But paradoxically, this does not match the doctor's own inner perception tinged by doubts and self-reproaches! For some colleagues it really takes time to understand that they are as good as they are.

I recall a discussion on this issue in one of my groups. A GP specialist, also a specialist in internal medicine (I could write a small essay in praise of her versatile clinical qualities ranging from remarkable diagnostic skills to psychological mindedness, and deep commitment to her patients) said:

“I am always doubting myself, feeling like a fake. It is terrible. But the good thing is, nowadays, I do not let my patients see it”.

It just slipped out of her. Of course she knew, and the group knew, that this was not the complete truth about her self-image as a professional. But I think that she put something into words which we often underestimate.

The psychological mechanisms are complicated and can be phrased in many ways, i.e. in those psychoanalytical terms that the prominent psychoanalyst Michael Balint advised *against using* in Balint groups. But even if we hide them behind doors carrying signs like *transference* and *countertransference*, *projection*, *projective identification*, and *depressive introjective propensity*, *unconscious guilt* etc etc - does this mean that Balint leaders should be unaware of what is behind those doors, and not be able to think about how group members could be given access to inter-psychic and intra-psychic reflection? Balint leaders, who are well marinated in the Balint tradition do have a good grasp of the realities behind these concepts and will know how to make use of them in group work, using plain language, also allowing for group members to develop their own language on psychological matters.

Missenard (13) conceptualized one aspect in *The Ideal Medical Self* which silently exerts its power inside of many conscientious doctors. This Ideal Self might serve as an unreachable standard which we will always fall short of. True enough, medical ideals have a positive value, but the flip side is that they may trigger a Procrustean inner situation which can deplete many a good doctor. Now, not every doctor is conscientious, committed, and sensitive. But doctors in voluntary Balint groups tend to be. I wish that politicians and administrators, for the sake of the citizens who have empowered them, would be more aware of the importance of this asset under their banner. They play a very important role for the sense of safety, coherence, and cohesiveness in a democratic society.

The vicissitudes of Balint group work

A Balint group can help in clarifying professional discomfort and confusion. Many of us have experienced small miracles, epiphanies - how on some occasions a group discussion can quickly help a bewildered doctor gain insight, or to become more conscious and less impulsively acting out, or to begin questioning why they comply to unrealistic demands.

But Balint work is not always a bed of roses. That is how Michael Balint himself introduced the method to his prospective members. Group participation, even under favourable external conditions, may temporarily be up-setting since the professional defenses and habits of the doctor, although dealt with in a considerate way, nevertheless may constitute *a challenge to the doctor's equilibrium* – be it internal or external.

Sometimes the impossible working conditions of doctors are exposed through the group discussions. The presenters tend to defend themselves like loyal children who try to make their best in a dysfunctional family by blindfolding themselves to the worst insights. Thus, with loyal and hard-working doctors, it can take quite some time to see the naked external realities.

Mind you, this also applies to the Balint group members in relation to the skews and dysfunction of the group and its leader! We must therefore be open to any kind of criticism and feedback of “bad/negative” feelings and thoughts that our discussions are triggering. A colleague will be saying:

“I felt miserable after the previous meeting, I did not know what to do with myself and with all the viewpoints you offered. And you as a leader were not of much help either”.

Those without Balint experience may think that such a remark would be the start of a deterioration in mutual trust. But in my experience with only two exceptions in 38 years, it is the other way around. It is a way to assert oneself and constructively criticize group work. It will help the presenters to gradually work through their difficulties, and it will help the group and group leader to reflect on what we are doing to each other.

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