INTERNATION BALINT GROUP LEADERSHIP CONFERENCE
CONTAINMENT, CONFLICT AND CREATIVITY

Balint Group Leadership: conceptual foundations and a framework for leadership development?

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IBF Leadership Conference Warsaw 2016

'Speak what we feel not what we ought to say' **(Shakespeare: King Lear)**

This is our fourth international conference. We meet together to work and think about the *difficult task* of leading Balint groups: fifty eight of us, from nineteen different countries all with different histories of the way Balint work has developed. Some countries have maintained a strong psychoanalytic input to leadership, whilst in others a greater interest has been shown by psychologists. And in the UK, we were fortunate to have Enid Balint and Michael Courtenay continuing to lead research groups for GPs until 1993 and 2000 respectively, many of whom subsequently became leaders.. In 2009 IBF began the process of putting these various strands together and now holds an international conference for leaders every two years. Following the first in Copenhagen (2011) and then one held in Charleroi (2012), the third conference which was due to be hosted by the Israeli Balint Society in 2014, sadly, had to be cancelled. Following the cancellation, the leadership task force met in Tel Aviv and at that meeting (held on one of the coldest days ever in Israel) suggested establishing a framework for the development of leadership training, and that this should include *the principles and concepts which underlie Balint work.*

So here goes!

The Question

We often refer to the Balint 'family' but how much do we really know about *how each other think* about Balint leadership? **How clearly do any of us conceptualise what we are doing when we lead?** A colleague at a recent meeting in Salzburg said to me 'there seem to be *so many different ways* to lead a Balint group'. In another

group at the same meeting a role play was initiated. Many aspects of leadership would be quickly agreed, at least in outline – clear boundaries, focus on the doctor-patient relationship - **but is that enough?** Against what theoretical background do we debate the value of a particular technique or the relative merits of an intervention we make (or, just as important, not make)? In short, is there a set of Basic Balint Concepts (a kind of BBC!) which form an agreed *conceptual framework* for our work? After all, there are many close relatives to Balint work. **Is all group work that focuses on the doctor-patient relationship Balint work?**

In some ways Balint groups are deceptively simple and eschew theory other than in the structuring of the group itself. Apart from the Appendix on Training in The Doctor, His Patient and the Illness (Balint 1957), the Balints wrote little about their own approach to leading groups. The experience of Michael Balint's leadership has been described as 'like taking strong medicine'(Courtenay 1994). And another early colleague of Balint's wrote 'with Balint around there was no let up on the pressure for investigation and discovery… one might easily become alarmed at the amount of turmoil Balint's leadership encouraged (Gosling 1996)'. In contrast, Enid had a deeply containing presence, and when leading a group created a secure but challenging atmosphere. She was tough-minded and had an extraordinary capacity for tolerating unknowing. It was her view that a Balint group was a special and highly sophisticated *'instrument'* for observing key aspects of the doctor-patient relationship which would otherwise go unnoticed and unstudied. It is easy to see what a formidable pair they were when working together. It was Enid Balint who later encouraged the development of GPs becoming leaders.

Underlying Principles: Psychoanalysis, Medicine and Mutuality

Although originally called research-cum-training seminars, Balint groups are rooted in the reality of the consulting room where body and mind are one and where the burdens of medical work are great. The research was twofold: to explore how things *are* in a particular doctor-patient relationship, to study the pharmacology of the drug doctor; and secondly, to evaluate the changes that occur in the subsequent interactions between doctor and patient after discussion in the group. The first of these research aims – for an individual doctor to explore her own way of being a doctor - remains the principal reason for any doctor to enter a group. Conventional medical thinking

objectifies the patient but in the Balint consulting room a move is made to a two-person psychology. With this move comes the central dilemma of all personal doctoring - the limitations of our self-awareness, our so-called blind spots or observer error. Balint groups offer us a 'third position' from which truly interpersonal professional relationships can be more fully realised. Psychoanalysts and psychotherapists who work in Balint groups do not bring psychoanalytic theory but an open-minded attitude to enquiry and a special atmosphere of attention; listening, preparedness for contradiction and a long term view of human relationships with awareness of their unconscious aspects.

The mutuality of work between the two disciplines (psychoanalysis and medicine) has always been central to Balint work. Both Balints were clear that an analyst (or psychiatrist, or psychologist) who had not been subjected to what they called the *thinking, feeling, despair and pleasure* of family doctors was not equipped to lead a Balint group. It remains true that most Balint societies require psychotherapists and psychologists to gain experience of working in groups before training to become leaders. But the Balints' phrase carries more than this. It expresses humility and the need for leaders to be aware of what they don't know, and encourages them to feel and think *alongside* their group members in a spirit of shared enquiry. Whereas originally the creative partnership was between leader and group members, that partnership now often resides additionally in the co-leadership pair, one from the psyche professions and the other from medical practice. **But both must make a journey, in becoming Balint leaders – analysts and non-analysts alike – into a Balint *'space of special expertise'* by working together** (Courtenay, 2004). The American literary academic Kathryn Montgomery states 'Despite its own emphatic claims to the contrary, medicine is not a science at all – and nor, incidentally, is it an art. Medicine is a practice.'(Montgomery 2006) Balint group leadership is certainly a practice and the internalised experience of *being in* a Balint group (for as long as feels necessary) remains the best possible starting point for our eventual attempts at leadership.

I now want to sketch what I see as **the cornerstone of Basic Balint Concepts**: the parallel process between consulting room and group and vice versa.

Parallel Process: The Consulting Room and the Group

We speak a lot about parallel process in Balint work. The significance of parallel process arises from our understanding of the interpersonal relationship between patient and doctor. In The Basic Fault (Balint 1968) Michael Balint uses a rather striking phrase to describe an early aspect of the mother-infant relationship: he calls it a harmonious interpenetrating mix-up. The doctor-patient relationship may not always be harmonious but it can often be an interpenetrating mix-up! Echoes of these early parent-child relationships come into the doctor-patient relationship all the time and are intensified by examination of the body and anxieties about death and dependency. Sometimes resembling a marital relationship, the long-term familiarity of the doctor-patient relationship can further entangle the mix-up. When a doctor brings a case to a Balint group, *patient and doctor arrive in the group together*. As members of the group listen to the freestyle presentation of her case, the doctor's emotions become clearer, as do her defences or blind spots. Sometimes the doctor demonstrates a close identification with the patient and at other times takes pains to distance herself. As Gosling expresses it, 'whatever the psychological distance, the patient is always present. It is one of the tasks of the leader to encourage the group to discover in what ways the patient may be influencing the doctor and to distinguish the patient's influence from the doctor's own distorting tendencies and professional needs' (Gosling and Turquet 1967). Who is speaking? Is it the patient or the doctor? Perhaps we need to be careful when we use these apparently distinct and deceptively circumscribed words 'doctor' and 'patient'.

Both are more porous than we imagine.

As discussion of a case proceeds, different aspects are taken up by (or will subdue) different members of the group according to their personal psychological disposition. In a well established group, a leader may become familiar with the group member's personal patterns of reaction, enabling him to 'read' the case in the reactions of the group. The leader tries to listen to how the group takes up the case and how the other doctors in the group work with the presenting doctor. It is these processes that are the focus of the group work as the detailed interaction between doctor and patient is revealed in the parallel between the participants in the group and the presenting

doctor. All this, of course, the poor leader has to try and observe as well as being part of the process – the very model of a modern participant-observer! The leader has to be prepared to be alone in his role and to withstand the many pressures to which he will feel subjected.

Perhaps we can say, as a **Balint Basic** that there are three key inter-connected layers of relationship in a working Balint group. The doctor-patient relationship as expressed to the group by the presenting doctor; the relationship that develops between the participants in the group and the presenter as the case is discussed; and the relationship between the leader(s) and the group (Elder 2007).

Work of the Group

Medicine is about serious matters. Tom Main, a close colleague of the Balints reminds us in a comparison between medicine and war, 'that both are concerned with issues of life and death, crippledom and loss, sadnesses and terrors about external dangers; and both are also complicated by anxieties from the inner world, unconscious fantasies of primitive sadism, punishment and so on' (Main T 1978). Just as doctors have their necessary defences which enable them to function in a professional setting, so do individual group members and groups as collective entities. Some of these defences will be personal or derive from disturbing aspects of the case whilst others will be connected with the unconscious preoccupations of the group itself.

How do we think about groups? **If we come to leadership without psychodynamic training do we simply absorb enough about group process to lead a Balint group?** There are different theories of group dynamics. Michael and Enid Balint were not much interested in group theory. It was the Balints' colleagues at the Tavistock – principally Robert Gosling and Pierre Turquet who developed Wilfred Bion's theory of groups to elaborate the theoretical foundations of the work of a Balint group and the role of its leader. Their slim volume 'The use of small groups in training' (Gosling and Turquet 1967) sets out their ideas clearly and is an invaluable discussion on the role of the leader in a Balint group. They describe the unconscious defences found in all groups which distract the group from pursuing its primary task. How we think about our role as a leader in a Balint group depends on our view of how groups

function (or refuse to function). Groups will sometimes do almost anything but stick to their task! How do we understand such things? Some of us may have a benign view of group function and feel that a group left to its own will work. I'm not sure I share this view. The balance between needing to lead and allowing the group to find its own way is a delicate one. In our first conference in Copenhagen, Tove Mathiesen raised the question of the terms we use for leaders: facilitator, conductor or leader? **Which do we choose and why?** My personal preference is for leader: in the sense of leading into awkward places, creating space for the group where it may not want to go. If the leader can't go there, what hope for the group? If the doctor can't go there, what hope for the patient?

Parallel Process: The Group and the Consulting Room

Parallel process goes both ways. It is one of the cornerstones of Balint theory that the attitude of the leader and the atmosphere of the work in the group become incorporated in the doctors' work back in her consulting room. Eventually, the reflective function of the group (the third ear or third eye) is carried within the doctor when she is consulting. **Perhaps it is helpful to think about Balint work both beginning and ending in the consulting room, continuously circuiting through the group until internalised in the participating doctor.** Michael Balint was clear: 'perhaps the most important factor is the behaviour of the leader…if he finds the right attitude he will teach more by his example than by everything else combined' (Balint 1957). This takes us to the paradox of teaching. The injunction not to teach is easy to understand, even if not to fulfil! Balint is clear about the ever present dangers of the teacher-pupil relationship and the mutual admiration society (Balint 1957). Leaders are advised to be on constant alert against encouraging a dependent relationship between group and leader. This is harder to avoid than we may think. **And it may be particularly so in mono-professional groups: a GP leader leading a group of GPs or a psychiatrist leading a group of trainee psychiatrists for instance.** But the second bit is trickier to study: that a leader is influencing the group all the time by his behaviour and attitude. So, we mustn't teach but everything we do is teaching! The question to study becomes not whether we teach but what we teach. For Balint this was about the group as a laboratory for learning deeper listening. 'After all, he said, the technique we advocate (in leadership) is based on exactly the same sort of listening that we expect the doctors to learn and then to practise with their patients'

(Balint 1957). The emphasis on leaders not teaching arose from the Balints' concern that doctors should find their own way and not short-circuit their experience of working through to new ways of thinking. Although it is important for group members to feel free enough to explore their fantasies and irrational thoughts, the loop back to the consulting room also provides the necessary reality testing of the group's ideas. Leaders need to bear in mind that the presenting doctor is the only person in the group who has actual contact with the patient. For this reason, follow-up reports were always encouraged by the Balints and their colleagues.

Developments

Now I want to step aside and in the light of what I have said so far, consider some of the changes and developments that have taken place in Balint groups.

First, a word about co-leadership. Although many groups are still led by single leaders, there has been a slow growth in co-leadership as a preferred model, often with pairing between GP and psychotherapist. In the feedback from previous conferences co-leadership has always featured highly as an area that participants have wanted to think about further. And when we launched our internet discussion group, a dilemma arising out of co-leadership was the first subject offered for exploration. Co-leadership gives the possibility of a 'reflective pair' and the value of mutual de-briefing after a session. Leading on your own may feel more exposed but can feel freer. For members of the group, the feeling of being contained by a parental couple will clearly be stronger in a group with co-leadership, and correspondingly, there may be more rivalry for a single leader's attention or a desire to pair with him or her. **Whether leading singly or in a pair, every case will put pressure on the leaders in different ways depending on the unconscious conflicts present in the case.** And there are many potential fault lines for the case material to exploit: different professional backgrounds, gender, and perceived or actual seniority relationships in the co-leadership pair. How does each leader think about their role? How much time is given to discussing these things? Does some discussion between co-leaders occur in the group? In on-going groups these issues increase in importance and underline the need for a clear structure of supervision for leaders.

The next area I want to highlight is a subtle shift in the aim of Balint work towards a more explicit concern with morale. Low morale and illness amongst professionals are of great concern but there is a need for clarity about the role of Balint groups as a potential remedy. Some authors have questioned the role of Balint groups in this regard arguing that in contemporary healthcare with widespread demoralisation of practitioners, groups with more of a work discussion focus are needed (Wilke 2001). It is true that such groups may well be helpful. From a Balint point of view, perhaps some confusion has arisen because of our need to undertake quantitative studies to demonstrate the benefit of Balint groups. In doing this, researchers have often used measurable outcomes related to morale. The aims of a Balint group for medical students or for professional trainees are different from those for a long-term group. Outcome measurements for educational groups are quite properly tailored to relevant educational aims. Groups with different aims require correspondingly different approaches to leadership. However determined we are on surviving in our educational and professional environments, it is important not to lose sight of the more subtle aims of long term groups with their focus on observable changes in the doctor-patient relationship. Such changes may not be possible to measure but they are possible to observe and describe through the lens of a Balint group.

The relationship between Balint work and morale is complex. Clearly patients are unlikely to be helped by demoralised or depressed doctors. And doctors may need to have sufficiently good morale to work in a Balint group at all. Balint group leaders may need to pay attention to the morale of participants whilst not losing sight of the fundamental object of Balint work. The paradox is put very well in Gosling's description of the early days of the Tavistock GP training scheme. He says their stated motto was **"All ye who enter here, take up your burdens".** He continues, 'No easy way out is offered. It is to be a struggle. Our general practitioners declare themselves to be harder worked as a result of coming to these seminars. The important change is that they understand their work better and derive more satisfaction from what they are doing; their morale is *therefore* higher' (Gosling and Turquet 1967). Nothing comforting or reassuring is being offered. **Improved morale may be the result of Balint work but is not the aim.**

Next I want to discuss the situation in which a leader decides to step outside his usual role and suggests a role play or suggests sculpting the case or introduces some other technique in the middle of a group's work. **What do we think about this?** Some might find it fine so long as it's a group decision and that the use of such techniques has been pre-agreed by the group. Others might feel that the leader is acting something out and has given up the struggle of embodying the task of the group and has decided to write a prescription instead: 'why don't we try some of this…' As we know, prescriptions often get written at moments which are difficult to stay with – when feelings of helplessness, or of being stuck or not knowing - are hard to bear. Of course all interventions made by leaders – interpretations, observations, periods of prolonged silence or being drawn into a conflict or pairing with a group member – all should be the subject of enquiry. **Two basic Balint questions are always relevant: why now? And what's going on?** Such questions would lead to an examination of what seemed to be happening in the group and the feelings in the leader's mind *at the point* when the suggestion (say, to role play or sculpt) was made. If we accept the earlier Basic Balint Concept - that the leader is always teaching - what is being taught at such moments? Is the leader teaching that when things feel unbearable you can take a short cut? Or, in saying this, are we expecting too much of leaders? Everyone has to find their own way. Heide Otten was fond of quoting one of her mentors in Balint leadership (Werner Stucke) who used to say: 'it doesn't matter what you do as a Balint leader but you must be aware of what you're doing.' It seems to me that learning to lead a Balint group is already hard enough and that to acquire skill in the use of additional techniques would be a step too far for most of us. **My main point is that we can only discuss these questions if we have a clear conceptual framework within which to do so.**

Balint Psychodrama, on the other hand, is a distinct frame with its own history, separate leadership training and explicit structure of work known to participants. As Jean-Pierre Bachman explains in the Journal of the Balint Society its origin stems from a synthesis between a Balint group and the quite separate tradition of psychoanalytic psychodrama. It is therefore not a Balint group per se, and is quite different from a Balint group in which a leader decides to introduce a new technique during the course of the group's work. The psychodrama technique is an integral and accepted part of a Balint psychodrama group. However, it is interesting to read that its

inaugural impulse was ‘a request for help in breaking out of a stagnant situation….a desire for a refreshing impulse from a technique that puts things back in movement’ (Bachmann 2015).

The technique of inviting the presenting doctor to ‘pushback’ during discussion of her case has been frequently debated in the last few years. In some countries it has become a widely used technique although it was not part of Balint methodology for the first thirty years or so. Clearly it has much merit; otherwise it would not have become so popular, but it also has some disadvantages. Some leaders may find it helpful to have additional structure when they are leading a group, others may find it encumbering. It is sometimes preferred by presenting doctors but preference by participants is not necessarily a good criterion for adopting practice. For those new to Balint it may be a help to have the reflective aspect of presenting a case protected, or ‘ring fenced’. If we view pushback from the perspective of basic Balint concepts, it does interrupt the dynamic of the parallel process between doctor-patient relationship and the group (by removing the doctor you are also removing the patient), and it alters the structure of (what I earlier called) the listening laboratory in the group. However these affects are mitigated if the presenting doctor returns to the group for a sufficiently long period before the discussion is closed. There is also a danger that a group encouraged to fantasise in the absence of the presenting doctor loses contact with the clinical reality of the doctor’s consulting room. The Balints were clear that the work should focus on the doctor’s actual work and that the aim of this was for the benefit of the patient. If pushback is used, it gives rise to an additional layer of attention for the leader as its use will alter the dynamics of the group discussion in different ways depending on the characteristics of the case presented, (say, if the patient had a history of repeated rejection). Pushback certainly underlines the experience of listening to oneself from the outside and thus can enhance the development of reflective capacity. As with so many things, leaders must find a way of leading that suits them but know why they have made that choice and what the relative merits and drawbacks are of their approach.

I’d like to give the last word on some of these developments to Enid Balint who wrote the following to Frank Dornfest at the time she was supervising him: **‘Leading a Balint group well is extremely complicated and the more you change individual**

components, the more complicated you make it, until you might make it impossible' (Don Nease, personal communication)

Containment, Conflict and Creativity

Our conference title is containment, conflict and creativity. In all Balint work there is the need for a secure frame which enables the freedom and creativity of the participants to flourish: whether in a group, a leaders' workshop, or indeed in a conference such as this. Conflict between members of groups and within individuals will always be present: conflict in the doctor-patient relationship; between colleagues; within organisations; and arising from sometimes strongly held views about political and social matters. Groups may increase anxiety about conflict and as a consequence, avoid, say, issues of race or sexuality which may be highly relevant to the doctor-patient relationship. Winnicott has described a leader as being an ordinary person in an extraordinary position. How much can any of us contain at any particular moment? **How much space is there in the leader's mind?**

There are many ways in which we could think about the creativity of a Balint leader: use of clear language which resonates with the group members, free of euphemisms or jargon; supporting the creativity of members of the group - perhaps thinking of leadership as something that passes from member to member; and allowing the group members time to discover their own ways of thinking about the difficulties presented. Disturbing ideas tend to shut down our thinking, close off our minds. Some of you will know the phrase 'negative capability'. The phrase came into the English language in a letter written by the poet John Keats to his brothers in 1817. Keats wrote:
'At once it struck me, what quality went to form a Man of Achievement, especially in literature, and which Shakespeare possessed so enormously- I mean Negative Capability, that is when man is capable of being in uncertainties. Mysteries, doubts, without any irritable reaching after fact and reason.

A Balint group is a place in which to explore and play with new ideas. The space for exploration in the group is, to a certain extent, a function of the negative capability in the leader's mind. Perhaps we could say: when a Balint leader is capable of being in uncertainties, mysteries, doubts, without too much irritable reaching after fact and reason.

Authenticity

It is all too easy for patients to feel reduced to a category, an illness or a particular type of patient. Being a doctor is also a category of a sort. Occasionally there is a meeting between an individual patient and an individual doctor. Two people meeting in a moment of truthfulness. Through such meetings the authenticity of the patient is strengthened. And the morale of the doctor enhanced. The patient is not being 'understood' in a way which might undermine. The doctor reaches beyond her white coat to a moment of healing. A doctor working in a Balint group can feel her professional authenticity strengthened. Not 'understood' by a leader who has a theory or imposes his knowledge but allows something to emerge from within. Authentic moments between leader and group can be part of the healing process in the doctor-patient relationship. And for this to occur, the leader must be sufficiently comfortable to lead in his own way. Not in any correct way but keeping in mind the **Basic Concepts of a Balint Group and the Leader's Role within that Framework.**

These are my own views and reflect my Balint background and my 'British upbringing' but I hope my talk opens up some questions about the principles and concepts that underlie Balint group leadership. To be explored further during our conference.

Thank You!

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