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Balint Group Leadership: Conceptual Foundations and a Framework for Leadership Development? (2017)

Andrew Elder[1]

[1] FRCGP DEd (Hon): andrewelder@blueyonder.co.uk

'A leader is an ordinary person in an extraordinary position' - Donald Winnicott

The Question

How much do we know about *how each other think* about Balint leadership? *How clearly do any of us conceptualise what we are doing when we lead?* 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 relative merits of an intervention we might make (or, just as important, not make), or the value of a particular technique, or shift in emphasis? In short, is there a set of Basic Balint Concepts (a sort 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?*

Apart from the Appendix on Training in *The Doctor, His Patient and the Illness* (Balint M 1957) and the two chapters that Enid wrote later in *While I'm here, doctor* (Elder and Samuel 1987) and *The Doctor, the Patient and the Group* (Balint E et al 1993), the Balints wrote little about their approach to leading groups. The experience of Michael Balint's leadership has been described as 'like taking strong medicine' (Courtenay 1994). Enid had a deeply containing presence, and when leading a group created a secure but challenging atmosphere. 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.

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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 professional work are great. The research was twofold: to explore how things *are* in a particular doctor-patient relationship (not how they should be); and secondly, to evaluate the changes that occur in the subsequent interactions between doctor and patient after discussion in the group. The training of course was to facilitate the participants' understanding and use of themselves as 'drug doctors'. 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; deep listening, acceptance of 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. At the outset 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. Whilst it remains true that psychiatrists and psychotherapists are required to gain experience of working in groups before training to become leaders, the Balints' phrase carries more than this. It expresses 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 (PA) and group members (GPs), that partnership now often resides in the co-leadership pair, one from the psyche professions and the other from medical practice. But in Michael Courtenay's words **'***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 one of the *cornerstones of Basic Balint Concepts:* the parallel process between consulting room and group *and vice versa between group and consulting room.*

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 particular understanding of the interpersonal relationship between patient and doctor. In *The Basic Fault* Michael Balint (1968) uses a rather striking phrase to describe an early aspect of the mother-infant relationship: he calls it a harmonious interpenetrating mix-up. The professional-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 professional-patient relationships all the time and can be 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 a case, the presenter's emotions become clearer, as do their defences or blind spots. Sometimes the presenter 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). In other words, who is speaking? Is it the patient or the doctor? Perhaps we need to be careful when we use those 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 (often called valency). In a well-established group, a leader may become familiar with the group member's personal patterns of reaction, enabling her to 'read' unconscious aspects of 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 participants work with the presenter. 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 reactions of the participants in the group and the presenting doctor. All this, of course, the poor leaders have to try and observe as well as being part of the process. The leaders have to be prepared to be alone in their role and to withstand the many pressures to which they 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 work of the group. Another important relationship for a leader to consider is that between herself and the presenting doctor (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 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 many 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! 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. *Facilitator, conductor or leader? Which term 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). 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. 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 also 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? In on-going groups these issues increase in importance and underline the need for a clear structure of supervision for leaders.

Pushback

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 more. Clearly it has some 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 or defensive. 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 effects 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. 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. *My main point is that we can only discuss these questions if we have a clear conceptual framework within which to do so.*

I'd like to give the last word on this to Enid Balint who wrote the following: *'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.'*

The last area I want to highlight *is a subtle shift in the aim of Balint work towards* a more explicit concern with morale. Low morale is of great concern but there is a

need for clarity about the role of Balint groups as a potential remedy. 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 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.*

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.

Conclusion

In all Balint work there is the need for a secure frame which enables the freedom and creativity of the participants to flourish. There are many ways in which we could think about the creativity of a Balint leader in attempting to embody that frame: 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 thinking. 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. Borrowing from Keats, 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.* And for this to occur, the leader must be sufficiently comfortable to lead in his or her 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.*

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