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Article

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Classic Balint Group Work and the Thinking of W.R. Bion: How Balint Work Increases the Ability to Think One's Own Thoughts

Ulrich Rüth

Some of W.R. Bion's specific ideas can further the understanding of the classic Balint group technique. The group leader supports a 'container-contained' process, preventing the group from attacking or criticizing the presenter.

'Projective identification' helps the group to understand what has been presented. Meaningless impressions, feelings, emotions, and simple facts are transferred to the group, such as still unthinkable bizarre 'beta-elements' to be transformed by the 'alpha-function' to the now thinkable 'alpha-elements'.

Abstaining from the group process, the presenter is protected from re-projections of feelings and emotions. The Balint group technique makes sense to promote the 'digestion' of bizarre beta-element-like aspects into alpha-elements, enabling the presenter to 'think his or her own thoughts' instead of projected one, giving the chance to change into a response model instead of a reacting one. 'Mental growth' occurs when feelings and thoughts can be tolerated at a higher level.

Key words: Balint group, Bion, response model, group dynamics, projective identification

1. Introduction

Michael and Enid Balint began running seminars for general practitioners or family physicians in the late 1950s focusing on the

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doctor–patient relationship, where it is particularly noteworthy to discuss it in a regular group meeting. Only later were these seminars called Balint groups.

In a Balint group, one of the participants presents a query or challenging situation from everyday practice. Once having presented, a few questions are allowed. In the classic setting, the presenter then steps back a little and does not take part in the forthcoming discussion. The group process takes place working through the presented case by expressing fantasies, commentaries, emotional reactions, and body impressions. The presenter should abstain from the group and merely listen. Only towards the end may he or she join the group by giving hints of what has been helpful or difficult. In the traditional Balint group, the leader does not give a specific recommendation or advice like in a supervision group. He or she encourages the members to arrive at their own conclusions after exploring how they feel and think about the situation. Michael Balint himself thought that taking part in a Balint group would not change general practitioners into psychotherapists but could bring about a considerable, though limited change in the doctor's personality (Balint, 1957).

Publication and research on Balint groups was done on different topics. Balint group work seems to promote an improvement of communication skills (Bascal, 1972). Participation changes the type of patients the doctors are said to have difficulties with, while those who drop out of the running group might not bear the fact that their patients are far more problematical than they initially thought (Dokter et al., 1986). In a comparative study (Kjeldmand et al., 2004), the 'Balint physicians' reported better control of their work situation, they thought less often that a particular patient should not have come for the consultation, and they less presumed that psychosomatic patients were a time consuming burden. Furthermore, Balint doctors were less inclined to refer patients to a colleague, or to take unneeded tests to terminate the consultation with the patient.

Concerning qualities of communication and relationship, Balint group work promotes attributes of the relationship instead of specific communication skills, the first consisting of deep listening, mindfulness, sincerity and genuineness, compassion, intimacy, and modesty (Matalon et al., 2005).

Effective Balint group leadership focuses on the establishment and maintenance of particular group norms such as self-reflection and exploration of meaning, rather than problem solving. It is necessary

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to create a safe environment that models empathy and allows for divergent viewpoints. The Balint leader avoids making any group member the object of a teaching lesson, or of psychological analysis (Johnson, et al., 2004).

Balint work is widespread over the world, although it is recognized by the 'Balintians' that many doctors do not want to lower their defences and take on a greater share of their patients' distress (Salinsky, 2002).

In some ways, what happens in the classic Balint group might seem strange: highly paid medical personnel sitting together with one of their colleagues telling a story about a difficult patient. Then, instead of discussing what to do and how to work on the problem, the one who presented the problem listens without actively sharing in the discussion. He or she waits, and lets the other members of the group play out their ideas and fantasies. He or she takes part again after quite a while towards the end of the group session, but finally all of them leave the room without a specific solution to the presented problem, or an algorithm worked out for their colleague on how to carry on. Taking part in a classic Balint group and presenting the case of a difficult patient increases the ability to think one's own thoughts when meeting with the patient again—which means shifting from a reaction model to a response model (Symington, 1990) and not being hindered by psychological problems.

How this works should be outlined by some ideas of W.R. Bion, a short view on the differentiation between reaction and response models, and the clinical aspects of classic Balint group work.

2. The Thinking of W.R. Bion

W.R. Bion lived from 1897 to 1979. He is sometimes referred to as the genius psychoanalyst after Sigmund Freud (Bléandonu, 2000 [1994]). He neither founded a Bion society, nor left a heritage easily to understand and use in practice.

Ideas important to what will be outlined are as follows (Bion, 1962; Symington and Symington, 2001):

1. The idea of a container-contained process in almost all human relations.
2. The idea of projective identification as a means to communicate emotions, feelings, and even thoughts usually unbearable or subconscious, first to be found in the mother-infant relationship but universal to all human relations.

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3. The idea that impressions, feelings, and emotions have to be transformed by the psyche from so called bizarre β-elements to so called α-elements, which can then be used to dream and think.
4. The idea that mental growth happens when we learn to bear feelings and thoughts which were at first unbearable.

The concept of container-contained as a process of thinking can be first adapted to the early mother–infant relationship when things run well. The mother bears the feelings and emotions of the infant in a holding environment, thus containing the feelings and emotions of her child. Likewise, any relation between an individual and the surrounding group can be looked at whether or not it is a relationship promoting emotional security and growth.

Projective identification is understood as a means of communication by which unbearable emotions are transferred to another person. This process is best known in the early infant–mother relationship when the mother 'knows' what is happening with the child without any means of talk. It is also known in patients organized on a low functioning level, such as borderline patients, who tend to evacuate intolerable feelings or unbearable emotional aspects of their personality into different members of a team in hospital treatment, thus engendering phenomena like splitting.

Bion puts the very beginning of thinking at the point when mere impressions and bodily feelings without meaning and sense—bizarre β-elements—are transformed into something meaningful and sensible—α-elements—to be used for dreaming, thinking, and building the apparatus to produce thoughts and linkages. This transformation is first to be done by the infant's mother, helping the baby to develop an α-function of its own that will transform future impressions and feelings. In the case that impressions and feelings cannot be digested by the α-function, the psyche tries to get rid of such senseless feelings and sensual data by evacuation, either by projective identification, or by other defence mechanisms such as acting out.

According to Bion, mental growth occurs when impressions, feelings, and ideas can be assimilated into something sensible such as α-elements and can therefore be tolerated without means of evacuation.

3. Freedom of Thinking while Responding Instead of Reacting

Symington (1990) underpins that one of Bion's main targets was the freedom to think one's own thoughts instead of projected ones. Based

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on this assumption, Symington differentiated between reacting and responding to another person. While reacting, projective mechanisms make us take in projected thoughts or feelings, or we try to evacuate such contents into another person by projective means. That way, thinking our own thoughts becomes impossible. On the other hand, when responding to another person, we try to get into contact with his or her personal centre. In a response model, we give the possibility of an emotional intercourse, while our response is based on our own thinking and feeling. When responding, freedom of thinking is possible because emotional knowledge of one another aims at each other's personhood. While reacting, emotional aspects are omitted, put aside, acted out, projected, or intellectualized, which means dealing with primitive defence mechanisms. When such defence mechanisms and primitive projections are dissolved, freedom of thinking one's own thoughts can take its own form and responding to another person's needs and existence becomes possible.

4. The Classic Balint Group Work looked at in a Bionistic Way

The Balint group functions as a container that bears, holds, and contains the doctor–patient relationship. In the beginning, it is the story of a difficult patient and the doctor's relationship to this patient that is presented to the group, and is therefore to be contained by the group. Frankly, the presented problem is voluntarily and with full permission evacuated into the group based on the Balint group's working habits. Thus, there is a difference in what happens in early childhood, or with pathologic projective identification—everything happens willingly and according to certain rules accepted by the group members.

One step further, the presenter leans back and keeps silent for most of the forthcoming session. Hence, all the problems, feelings, and even projections of the patient and the doctor are handed over to the group and its members symbolically, but also in a very concrete manner, to be discussed—the group now serving as a 'container'. This is very similar to the early mother–infant relationship when the child presents its feelings evacuating them into the mother to be contained and to be transformed by the mother so that they will become more tolerable.

The group now contains all the aspects of the doctor–patient relationship, as well as anything having to do with the emotional difficulties arising in the patient, the doctor, and even in the Balint group

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itself. According to Bion, in an early infant relationship, the mother transforms bodily impressions and emotions of her baby by her own alpha-functions into something different and more bearable that can then be re-introjected by the baby, and makes a very early process of thinking possible. Within the Balint group, participants having listened to the story are then generating impressions, emotions, and ideas that arise among the group, as in a mother who 'dreams' her child while trying to understand how to help.

As long as the presenter keeps mute, any feelings, thoughts, and ideas spoken out among the group are once again re-projected into the group instead of being evacuated into the presenter. This way the group is forced to continue a process of psychic digestion that consists of transforming the bizarre elements of the doctor–patient relationship—β-elements—into thinkable emotions and ideas—what Bion called α-elements. With every new aspect, with every new idea spoken, this digestive process of thinking continues both in a very conscious but also in a half-conscious reverie-like way.

What the group gives back to the presenter who keeps silent is like all the different tastes of a rich meal taken apart and reintegrated by the listener in a way that will be delicious to him or her. The listener is free to take or to reject the spice, and the ingredients of the meal that is offered. Nobody is forced to accept anything. Everything happens within the group working together like on a stage. The listener can look onto the group and hear what is spoken, or even acted out. They can decide on their own what to take and what to leave aside in order to achieve a greater amount of freedom to think.

If the listener had to participate actively in the group, they would have to react to what was spoken by the group. They would add what they think they might have omitted, would perhaps add their own new impressions, would begin to discuss, and therefore get into the group process itself. In doing this, they would lose their own thoughts. By actively taking part in the group process, the presenter gives up the very precious freedom of not reacting, not saying anything, just thinking their own thoughts during that one hour that the group works for them. Thus, the setting of a classic Balint group paves the way from a reaction model to a responding one.

5. A Short Vignette

Let us take a look at a short vignette that illustrates the thoughts conveyed above.

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Doctor P., a general practitioner, tells us about a patient in her thirties, a teacher with backache, who comes to the consulting room every once in a while, very late in the afternoon just before he is preparing to leave the office to visit patients, or to go home. She comes along with acute symptoms and asks for urgent help, usually injections, which she gets. Her husband runs a small restaurant or bar in the nearby town. He brings the patient to the consulting room by car and then leaves for work. The problem is: how will the patient get home after the injections when she is still in pain and there is no car available? Once, Doctor P. asked his assistant to take her home. He feels uncomfortable taking her home on his own although it is on his way. She knows where he lives.

Once, he took her home by himself. She also phoned him once and he had to visit her; her husband was just then leaving for work.

Doctor P. thinks he should send his patient to the radiologist again, as there might be a certain impending organically based danger. He also thinks there might be a psychological problem. Should he send her to a psychologist? The Doctor says he is not at ease with the patient and he hopes she does not return too soon because in some ways he cannot really help her.

What the Doctor is telling us is that he would like to get rid of the patient—and of all the disagreeable feelings he has in having to deal with her case. However, he tells the story because he is interested in growth—his own and his patient's. At first sight, feelings and facts are 'projected' or 'evacuated' into the group as a container. It will be up to the group members to explore and to feel and to think what the doctor and his patient have not yet felt and thought consciously.

While listening to the story, the group 'contains' and 'holds' what is presented, giving a starting point to psychic growth. Emotional reactions arise as a first result of projective identification. Some questions about medical aspects and life circumstances of the patient and the Doctor's answers help the group to continue this holding process, and to keep the process of projective identification at a certain distance. The moment the presenter sits back in his seat in the classic Balint group and keeps silent, the group starts to 'digest' what they have heard. The group members try to assess what might have been told between the lines using the mechanisms of projective identification. Furthermore, they try to find out what has been unthinkable in a conscious way, being presented merely as facts or impressions much like unthinkable and undreamable bizarre β-elements.

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Let us listen to what is communicated as aspects of the doctor–patient relationship and what is therefore transformed into something more thinkable such as Bion's α-elements.

> Strange that she comes at the end of the consulting hour, brought by her husband, then having no car to return. Why doesn't her husband bring her in the early afternoon so that he can take her back?
>
> I myself would call for a taxi. That would be very easy. There wouldn't be any problem any more.
>
> Why doesn't she run the restaurant together with her husband? Why don't they have a second car? Or does she leave her car at home intentionally?
>
> I think the Doctor should see that medical diagnosis by the specialist is important. But, he might send her away in order not to be bothered any more. I don't think this will work, she will come back.

These quite conscious near statements and questions at the starting point, dealing with practical life, show that a communicative process has begun.

Another statement:

> What about money? Restaurants don't run well at the moment. Maybe they are both in debt. She wanted to get children and stay at home, and now things don't work because of the restaurant.

If the presenter had to take part actively in the group process, he would then add information thinking this could be important for the group's work and understanding. Or he might begin to discuss why he has not yet asked his patient about certain aspects of her life. By doing this, he would drift away from thinking his own thoughts. He would get into the group process itself.

Other remarks deal much more with unthinkable, β-element-like aspects that come to mind by projective identification. The group tries to digest what could not be seen before or looked bizarre when listening to the facts of the story alone.

> She comes when her husband leaves. He runs a bar. He will meet other women there. What kind of restaurant is this, which opens in the evening and runs until after midnight?
>
> I think that the patient's husband already has another partner. The patient knows this and she gets a psychosomatic problem. She wants to force her husband to stay with her at home, but this doesn't work. The husband leaves the patient with another man. He tells the Doctor that he can have her.
>
> The patient wants to seduce the Doctor. She feels alone when her husband is out at work. He works until after midnight. They have no sexual life. It is not her back that is aching.

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> I think she just wants the Doctor to take her home, and she wants him to come with her upstairs. That's why she makes her husband bring her along leaving her without a car. She wants to make her husband jealous by seducing the Doctor. But the husband doesn't mind unfortunately.
>
> She doesn't want to present only her back. At least, she has to take her clothes off to get the injections.

As long as the Doctor who presented his case keeps silent, all the ideas, thoughts, and emotions spoken out in the group are re-projected into the group as a container and not into the Doctor. This way the group is forced to continue a process of psychic digestion. The group has to work on transforming bizarre aspects and elements of the doctor–patient relationship into more thinkable emotions and ideas–what Bion called α-elements.

With every new aspect and idea spoken, the digestive process of thinking what previously seemed unthinkable continues. This way, α-elements are generated.

While the presenter keeps silent, everything happens within the group working together like on a stage. The listener can look at the stage without any need to intervene. He can take or leave what he can use to achieve a greater amount of freedom in thinking.

Listening without discussing helps to avoid projective identification to take place in a reversed way—that means ideas and emotions that are unbearable to the group at a certain moment are avoided and will be re-projected to the Doctor. The group must continue to contain and digest all the ideas and emotions to the very end of the group work without getting rid of them evacuating them back into the Doctor.

Another statement of a group member:

> Maybe she is an attractive woman. He has seen her husband, and now he is sorry for her. They are both attracted by each other. It is in some ways an oedipal situation.

If the listener had to participate actively, this would probably be the moment in which he could not help but react to what has been spoken. He would have to admit or deny. But then the digestive process of looking for means to communicate unconscious aspects and to digest them would come to a sudden stop.

By actively taking part in the group process, the Doctor would leave behind his very precious freedom not to react, not to say anything. He would miss the possibility to think his own thoughts while the group works for him. By merely listening, it is up to the Doctor to decide what he wants to take in and what he wants to put aside.

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6. Conclusion

What has been outlined as the core workings of a classic Balint group closely resembles the concept of a reverie supervision group (Berman and Berger, 2007) with the difference that the Balint group does not aim at supervision but at the doctor–patient relationship itself. We should keep in mind that this doctor–patient relationship is prone to very deep emotions because it has to deal with illness, mortality, and death. Feelings and emotions concerning our very existence are evoked. Very strong feelings usually cannot be tolerated by a single person, but must be projected into a container—a group like the family, or for example the caring Doctor. Emotions being projected into us hinder us from thinking our own thoughts—unless they are digested, which means they are taken in as parts of our own thinking or, on the other hand, they are excreted as a substance we cannot use and we get rid of by simple reaction.

Classic Balint group work aims at giving back to the participants the ability to think their own thoughts, and not to think what has been projected on to them.

Relating to the patient in a free and thus responding way, the Doctor can bring in his or her special ability and knowledge to heal. And he or she is less in danger of simply reacting to the patient in a way that gives the patient intolerable feelings without a chance of transformation and change.

Sitting together in the somehow strange way the 'Balintians' do is thus a very real way of making the Doctor think about the patient 'on his or her own' and therefore make his or her professional resources work better.

What about the Doctor from our Vignette?

Before telling his story in the Balint group session, Doctor P. could not think and feel all the different and partly bizarre aspects of the doctor–patient relationship. He did not want to look at how his patient had made him feel angry, helpless, seduced, used as a weapon against her husband, and used as a means of curing her loneliness. The group recounted to Doctor P. what was first unthinkable. Doctor P.'s own ability to work as a container and to hold aspects of the emotional life of his patient has grown. This growth took place by means of transformation from bizarre β-elements to thinkable α-elements within the Balint group.

When Doctor P. meets his patient again, all the aspects presented by the Balint group will have an influence on him—and on his patient.

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Maybe he will be able to speak to her about the real problems in her life, regardless of whether they may be money or sex, and help her regain physical and psychic health.

At least he will look at everything that happens between him and the patient and at what he can do for her pain in the long run, freely and with more distance.

This is what is required to take good care of one's patients, and what is brought about by freedom of thinking: to keep enough distance.

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