BALINT GROUPS FOR THERAPISTS

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Part One: Introduction

Michael and Enid Balint (Balint, 1972) developed the distinctive case consultation groups of that name for physicians. Balint groups were meant to help with how individual psychopathology complicated general medical practice. In those days the main issues were somatization, substance abuse and post-war problems. Of course, doctors still deal with those today and Balint groups for physicians now meet in more than twenty countries.

Early groups focused explicitly on how to use relationships therapeutically, and Balint's reports of sessions include members' treatment planning suggestions. He felt his earliest efforts were too didactic and pushed groups to evolve toward exploring possibilities rather than planning. As practiced now the goals of a Balint group are to support the members' freedom of thought and awareness, to help them tolerate the disparate feelings that come up, and to help them imagine wholesome directions or aspects of ill-functioning relationships. Because they do not rest on any specific psychoanalytic theory and do focus on individual, ongoing relationships, Balint groups are also potentially useful for therapists of diverse backgrounds and experience levels.

The format of a Balint group is implied by the questions the leader asks: *Who's got a case?* Is followed by a case presentation without notes. The kind of case that works best is one that haunts or bothers the presenter, and the most useful presentations focus mainly on a recent or characteristic interaction between the person and the provider. Once the group has heard the presentation, the presenter sits back and listens while the other members play with it, speculating about such questions as: *What is it like to be this patient? What is it like to be this patient's doctor or therapist? What is going on in the therapist-patient relationship?* The speculations that arise in answer to those questions are kept in descriptive, nontechnical language. They may take the form of metaphors or start with explicit references to their "as if" quality, e.g. "If I were this person's therapist I would feel…" or "If I try to put myself in the place of the client…." In the end the presenter is invited back into the group, but may or may not have a perspective to share about what has been said. The group's success is not to reach a specific outcome but to widen the field of what can be considered.

Part Two: Demonstration

Part Three: Effects of Balint Group Work

My paper will spell out the ways I have come to think about the effects of participating in Balint groups. One basis of these thoughts is my having led the Balint group for third year residents in Family Medicine at the University of Washington since 1995. I have also had other groups - for the faculty of a different residency, for the staff of a community clinic and for groups of private practice physicians from multiple specialties. Most recently Kris Wheeler and I have offered this kind of case consultation group for therapists with a range of experience and theoretical orientation. While some of my examples come from groups with physicians, I hope they will seem relevant to you for therapists as well.

It was Enid Balint (Balint and Norell, 1973) who realized that the physician, without becoming a therapist, needed to learn to tolerate being "used" for emotional purposes, a la Winicott. She also identified that the "flash" of genuine understanding between the physician and the patient signalled psychotherapeutic effectiveness, even in a visit of under ten minutes. Her insights have informed the evolution of Balint groups and make them uniquely appropriate for therapists.

Through affect-laden imaginings and speculations Balint groups give practice in understanding others, experiencing compassion, however difficult or painful, in a setting protected from any immediate need to act. Imaginatively 'taking on' a colleague's case, and tolerating not knowing, allowing multiple possibilities without resolution, give practice in being used for emotional purposes, or, when one is the presenter, in using others to good purpose.

While these skills have significant implications for medical doctors, they are arguably foundational to psychotherapy. What enables these skills to grow is not simply practice, but the repeated, intentional lowering of defenses in a relatively safe environment. Because this is required, such development is usually relegated to the therapist's own analysis and sometimes considered in the supervisory relationship.

Casement's (1985) writing about the process of supervision emphasizes establishing a "play space" and learning to do "trial identifications" with the client to assess the clarity of interventions. A play space, where one needn't have one's ordinary defenses, can be elusive, when supervisees are trying hard to please or before they have confidence in their own capabilities. In a well-functioning Balint group members quickly realize that much can be offered that might otherwise sound accusatory. In one Balint group a member offered the idea very tentatively that the client could be angry with the therapist. She was pleased to learn later that the presenter had heard this with interest and without being upset. Speakers own their thoughts and share them in a spirit of identifying with each other rather than talking about the presenter. "I would be mad at myself" is much more benign than, "You

blew that one." Even when discussing the client, speakers offer what they imagine, revealing themselves as well as investigating the case.

In Casement's examples of what he calls trial identifications he imagines aloud to supervisees how their remarks may have sounded to clients. He specifies that his providing this imagined material is a step toward eventual internalization and autonomy. Similar content is offered in Balint groups, with members imagining what the client may be experiencing in various contexts. In Balint groups the members all contribute, diluting the intensity of one-on-one dynamics and providing an experience that may help someone value diversity of opinions and otherness. While I do not believe there is any substitute for supervision, I do think Balint groups are uniquely qualified to broaden and deepen acceptance of affect.

Having conducted Balint groups for therapists, I believe they offer a powerful procedure to facilitate the development and experiential learning of sensitive, receptive empathy for the otherness of the patient. Kris and I have conducted two such groups. The first was comprised of relative beginners who found it fascinating and helpful. The second group attracted highly experienced practitioners of several psychoanalytic schools. They, too, found the discipline rewarding. Without exception each of our meetings accomplished the lowering of defenses I am claiming as an influential and vital aspect of the practice.

Thomas Ogden (2006) identified his own experience in a Balint group as a necessary, second phase of psychoanalytic learning, a phase in which learned procedures are "overcome… in order to be free to create psychoanalysis anew with each patient". He values the Balint group's creation of a "dream space" for its ability to rise above the "numbing automaticity" of our procedures. Like Casement's play space, Ogden's dream space exists beyond the need to act, beyond the need for everyday certainty, beyond the quotidian realm of defenses.

> Psychoanalytic teaching at its best opens a space for thinking and dreaming in situations in which the (understandable) impulse is to close that space. To fill that space as a teacher is to preach, to proselytize, to perpetuate dogma; not to fill it is to create conditions in which one may become open to previously inconceivable possibilities. With regard to teaching clinical psychoanalysis, a central goal of analytic teaching is the enhancement of the analyst's capacity to dream those aspects of his experience in the clinical situation that he has not previously been able to dream. (p.1069)

For therapists I believe the work of a Balint group may have as profound an influence on the development of one's professional self as analysis has on the whole person. If the case presented is the material, the group's work can be thought of as free association. At times the entire process may provide a kind of slow-motion tour of the lightning fast

preconscious activity that occurs in the consulting room or the therapeutic hour. When it works the Balint process certainly enhances its members' capacity to consider aspects of experience previously unavailable. At a higher level of organization a well-functioning Balint group embodies diversity and cohesion, so that repeated exposure to it may help us internalize and create for ourselves a more complex, nuanced sense of what it may mean to be a therapist.

The intentional lowering of defenses necessary to a dream space is easiest to see when the presenter begins with obvious constrictions, what is colloquially referred to as being defensive. By the end of the Balint group the rigid thinking has loosened. The toughness, as if one were refusing to be touched, has softened. And the need to make something happen has lessened. This can often be observed in several group members, not only the presenter.

But there are other, subtler signs of a group's success, since defenses operate constantly, not just when we are aware of strong emotions, and have subtle influences on one's moment-to-moment awareness and internal freedom.

For example, presenters not uncommonly forget details at first. By the end of the discussion the presenter will have become aware of omitted material after listening to her colleagues play with the case. Perhaps hearing people talk about the patient's imagined social supports reminded her of the patient's hint about arguing with relatives. Such remembering is fairly common and may happen with a feeling of relaxation or relief. Often the remembered material is neither weighty nor fraught with emotion, though it may be useful.

A second familiar short-term effect is that the presenter may relax and feel more compassion for herself. A presenter's lack of compassion for herself usually involves an oversimplified or harshly applied notion of what it means to fulfill her role. Watching colleagues own up to things one had been disavowing and seeing them do so without losing respect for one another provide excellent food for thought and growth.

In an example from one of my physician groups, the presenter began by saying self-critically, "This is really an easy case. I don't know whether it's even worth presenting." After hearing her colleagues talk about her patient with care and identify with her frustrations about communication, she said, "Wow. I said it wasn't complex, but I was wrong. It just wasn't medically hard, so I thought it should be easy. No wonder I've been having trouble!" Once she could relax her defenses and look at the whole picture, her relief was palpable.

Of course, part of that 'whole picture' is the practitioner's countertransference. I am using that term to refer to an overdetermined response on the part of the therapist that distorts or constricts clinical judgment and perception. When this has come up most clearly in therapists' groups, it is relatively easy to acknowledge. The speaker, usually a group member rather than the presenter, says something like, "I seem to be stuck. All I can

think about is the spouse we haven't met and how this person's acting out has hurt him." The group goes on to play with this possibility and to voice other possibilities, often profiting from the 'stuck' member's statement. The result, without explicit analysis, tends to be that the countertransferential observation was of interest but now rests among other possibilities. It can be lightly held and considered by all.

Less frequently, the presenter may speak candidly about countertransference: "This reminds me so much of my brother, I just don't know what to do. I keep thinking about him instead of my client!" Then the members try to speak about that experience: "If I were this therapist I'd be wanting to refer the client to somebody else. Get rid of him! Tell him I can't handle it!" "I'd feel guilty all the time, like it's my fault I can't do my job, but underneath it all I'd be mad at the client for stirring all this stuff up." In this way the presenter gets a detailed, sympathetic but unsparing picture of some of the potential ramifications of a countertransference reaction. Even when the members' speculations are not veridical in their fine points, the experience of such attention may well encourage the therapist's own reflectiveness.

When the group's work has not produced an internal shift or a new understanding for the presenter, that person may still be aware of some expansion of possibilities, a return of curiosity, as if to say, "I now have subjective room to be observant. Before I could only feel frustrated or confused or prepared for the worst." The group work has allowed a return to receptive, noncontrolling attention to difficult cases.

Finally the quintessential impact of Balint group is development of compassion for the patient. This always involves tolerating complexity, even contradiction. It may feel good to have compassion for the patient you find infuriating or offensive, but it takes work to do.

Looked at from this angle the short-term impact of successful Balint work is all about defenses that protect but constrict us. The presenter gets an internal signal that there is more to know or to understand about the case. That signal may be dread, inability to stop thinking about the case or discomfort about an interaction. The way to know more is to relax one's defenses, and, of course that's our fundamental trick: under the right circumstances, including those of a Balint group, one can relax defenses intentionally, even though the defenses arise automatically and unconsciously.

People who lead Balint groups are familiar with these effects: increased awareness or remembering, increased acceptance of experience, including tolerance for affect and tolerance for complexity, decreased need to judge self and others, and decreased need for control, including less need to know the answer.

These short-term effects achieved by the repeated intentional lowering of defenses develop their flexibility. The defenses don't change. You may still get overwhelmed and have thinking that is limited in a way characteristic for you. But if the way you use your defenses develops, you can recover more quickly. You have a more nimble mind.

An aside here: I do recognize the possible clinical utility of tolerating being unable to think, unable to keep our wits about us. I am talking about having flexible enough defenses to be able, generally speaking, to regain our wits and carry on appropriately enough.

Here's an example of what I'm calling flexible defenses: after feeling inept in a session the therapist responds fearfully to the client's calling to cancel the next appointment. The therapist feels "sure" the client is going to quit therapy. But he's been in a Balint group, so he can pause and think, "Well, maybe. Or maybe not." So the phone call continues and rather than trying to say the perfect thing to keep the client in therapy, he is able to be curious about what may be going on.

This example of flexible defenses involved little insight or complex integration. Certainly the therapist did not have an opportunity to work through his own desire to reject the client or to explore his sense of himself as worthy of rejection. There may be that and more for him to understand in this incident. But the sense of multiple possibilities, and the sense that it is okay, even useful, not to be able to think of everything created options that his defenses were on the way to impeding.

This kind of development, this maturation in the use of defenses is what I'm claiming as the longer-term impact of Balint work. Perhaps even more than therapists need strong defenses, they also need flexible ones.

Michael Balint (1972) hoped to achieve "a limited, though considerable, change in the doctor's personality" by prolonged exposure to Balint groups. He did not clarify what such a change would consist of, though he knew it would add reflective capacity and figurative thinking to the concrete, action-oriented skills that medical training encourages. I believe that the flexibility in the use of defenses I have described is the change in personality he was hoping for.

I want to emphasize that this concept of maturing in the use of defenses is not the same as using defenses that are more sophisticated. Someone might never develop the ability to sublimate, yet might still have improved adaptability by becoming flexible in the use of the defenses they have.

Subjectively, the development I am talking about shows up as an internal atmosphere that can be described by elements of mindfulness as measured by Baer et al (2006). The specific factors of non-judgment and nonreactivity apply here. For example, the non-judgment factor in mindfulness is represented by the statement: *I rarely tell myself I shouldn't be feeling the way I'm feeling.* A similar example for the nonreactivity factor is: *When I have distressing thoughts or images I am able just to notice them without reacting.* We could summarize those scales by saying: I tolerate internal complexity and keep my wits about me, an excellent description of the fruits of maturely flexible defenses (Ludwig & Kabat-Zinn, 2008).

My favorite metaphor for a Balint group's long-term effect on defenses is brain yoga: relax and stretch into this patient's point of view; now assume the position of the doctor. Hold it. Feel the stretch. This process happens no matter what the content of the case, and it can happen for all participants, even those who do not achieve personal insight.

Like yoga, it may feel good to do, but it also requires work and the rewards may accumulate over time. Like yoga, if you stretch too far, you may hurt yourself and not want to try it again. But if you are skillfully led to stretch more than usual, but not enough to hurt, you may feel good doing even a little bit of it. Doctors who are members of successful Balint groups often turn Balint into a verb and report that they are 'balinting' cases all the time with colleagues. They may be onto something: those quick two-sentence conversations in the hallway may be a way to practice lowering their defenses during the day in connection to their work, keeping them just a bit more flexible.

They may also be calling those quick check-ins with colleagues 'balinting' because they help alleviate the isolation of practice. Outcome research on Balint groups (Kjeldmand & Holmstrom, 2008) shows that doctors are most aware that the experience decreases their sense of isolation and that is an effect they value highly. Even in a brief Balint experience (Sherman, personal communication, 2011) with doctors from multiple specialties, where one might have expected less identification with others and lower trust, the most frequently cited benefit was reduced isolation.

But Balint groups aren't just an antidote to professional isolation, they are a specific, powerful antidote. Everybody in a group exposes their professional selves. Even if I have not had the courage or the felt need to present a case, each time I say, "If I were the therapist for this person….." I am revealing some aspect of my inner working life. It might be emotionally helpful to me to visit with some of the members of my group over lunch or tea, but really, I don't have to want to socialize with them. I may even find someone odd or off-putting and still get relief and help from the metaphor they offer about a case. Conversely, I may meet with a friend and return to my office feeling as alone in the work as ever.

This specific alleviation of professional isolation may be the closest thing we have to preventive medicine for such things as burnout and sexual transgressions with clients. Folman (1991) found that a subset of transgressing therapists may be having marital difficulties and report feeling lonely and isolated, making them more vulnerable to such trouble. One British study (Garrett and Davis, 2007) found that psychologists who had been in therapy themselves were more likely than those who had not to commit ethical violations involving sexuality. I suspect one thing that may send us into therapy is the sense that we're not in good emotional shape in our jobs. Therapy or consultation may shore up or even rebuild the underpinnings, but these are inherently inegalitarian relationships, involving someone who reveals and someone who does not. A Balint group offers both containment and the empathic support of peers who remain colleagues.

Because of this combination it may have unique power to reinforce appropriate boundaries while exploring the emotional experiences that challenge those boundaries.

Without demanding it, Balint group work encourages the complex integration of the emotional and the cognitive that can only happen with flexible defenses (Lichtenstein and Lustig, 2006). The personal is explored, within the limits of a specific, sometimes vivid case. The professional is expanded, not sweepingly, but within the limits of a specific case. In Balint group we learn without being taught (Bion, 1998) the way we all must to stay fresh in our work. The focus is the professional role, but the range of content is as wide and deep as the imaginations of the group members. Over time the impact of such a group may be, as I have asserted here, profound.

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