Jablonski, H. (2025). On Grief and Mourning in Clinical Practice. *Journal of the Balint Society, 50: 32-49.*

JOURNAL OF THE BALINT SOCIETY, VOLUME 50, 2025

On Grief and Mourning in Clinical Practice

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Before I started to work on this paper,[1] I asked a good friend, an experienced paediatrician who has devoted the larger part of his clinical life to children with chronic intestinal diseases, 'What do you think about mourning in everyday clinical work?'

'That is a difficult issue', he answered thoughtfully. 'It´s not only about mourning when patients die, but patients and their families also mourn the remaining disabilities.'

'Indeed,' I said. 'Now, what I had in mind is rather the mourning in you, in us, as doctors. How do we deal with it? How does it affect our libido economy?' – an odd phrase that slipped out of me, but he is used to my idiosyncrasies, but to make sure I added, 'How does it affect our lives as human beings both inside and outside of our surgeries? Which are the triggers for mourning reactions in us as clinicians?'

His gaze turned inwards. He obviously needed to rethink my question from quite a different angle. But would you not agree that his response is typical for many good clinicians? Their focus is on the patients and their families.

There is very little space in clinical everyday life for the doctor´s own sadness, grief and mourning. Authors on this subject refer to 'disenfranchised' reactions, i.e., unrecognised phenomena – often repressed or else manifested in a variety of ways. Our professional and personal psychological defence mechanisms prevent us in varying degrees from dealing thoroughly with impending strong emotional reactions. This is generally adequate, as we cannot compete with our patients and their families for the emotional space in the clinical encounter. Yet, when we are affected, how do we deal with it?

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[1] This text is based on the opening speech for the Swedish Annual Balint Conference at the Östrabo Bishop´s Farm in Växjö in September, 2021, on the theme of grief and mourning in clinical practice. A minor part of this text appears in an earlier paper, 'The Human Glue in Medical Practice and Balint Group Work: Coping with the Unavoidable Illusions and Seductions in the Doctor-Patient Relationship', included in the *Proceedings of The International Balint Congress* in Heidelberg, 2013. Inspiration for writing earlier versions of this paper is owed to Andrew Elder's (2009) discussion of the GP practice as a secure place for both patients and doctors.

An array of questions come to my mind. How does the cumulative experience of grief and mourning in clinical practice – be it recognised or repressed – affect the inner life of the doctor? How do we defend ourselves against the experience of grief and mourning? When are our defences adequate? When will the repressed affects constitute a potentially traumatising process? How does the personality of the individual doctor and his/her personal life experiences play out in the clinical meetings? And how do these issues show and play out in Balint group work?

Before we go into these issues, a general observation: Doctors, to a varying degree, have a need to underpin their daily practice with recognition and appreciation from their patients, colleagues, and staff. Nothing strange about that. Mutual recognition is usually an important part of most work relations. But I think it is worthwhile to look at this aspect as a mix-up of professionally adequate *and* personal (neurotic) intentions. Lack of recognition may be a source of mourning, depression, and frustration in doctors. Also, you can hardly talk about mourning and bereavement without talking about attachment, relation, and love.

Writing the draft for this paper,[2] many experiences came to my mind, mainly from the Balint groups I have been leading but also from my own clinical work. But why should I waste your time with them? You will all have innumerable examples of your own. I will present a couple of examples though after my attempt to discuss relatedness, grief, and mourning from a psychoanalytic perspective and my take on recurrent themes in clinical everyday life.

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[2] This presentation was originally planned as a joint venture with Stefan Bálint (1945-2019) from Malmö. Stefan was a Swedish psychologist and psychoanalyst, member of both the Danish and Swedish societies, and former chairman of the Danish. He was introduced to Balint work in the '70s by Professor Lennart Kaij, who had adopted the method after visiting the Tavistock that year. Stefan led groups for almost 40 years and trained leaders. At the time of his death, he was a full-time practising psychoanalyst making plans to retire in 2021. In July 2019, he had a bike accident that left him tetraplegic and confined to a respirator. He was mentally intact till his last breath five weeks later. We never found the time to coordinate our contributions. But you would have heard Stefan´s thoughtful reflections, so well grounded in his personality, in psychoanalytical theory and practice, and in his Balint work. Stefan, as an analyst, supervisor, teacher and Balint leader, was highly reputed, almost iconic, for his profound and useful take on matters. It is a pity that he had such a resistance to writing. But I see many of his partners and Balint disciples in this gathering today – carriers of an even more important oral tradition. So, for us who had the privilege to work with Stefan, our joint project goes on.

I will begin by touching on some psychoanalytic ideas. Firstly, I discuss the Balint vantage point on the practice of psychoanalysis and his thoughts on human psychic development. Secondly, I look at Freud's ideas of mourning, depression, and early psychic trauma. Thirdly, I bring in Winnicott on the transitional area. Drawing on these authors, I explore the traumatising potential of grief and mourning on 'both sides of the aisle' in clinical work.

Balint's formulations are not self-evident at all, even if they may seem so – neither in psychoanalytic nor in medical practice. He insisted on the value of treating patients in an informed, interactive, and benevolent way. Even in his English writings he used the German *arglos.* It is often translated as *non-intrusive,* which does not by far cover *arglos.*

The benevolence is missing and, in my view, so is the most important aspect – sincerity and honesty – which contain a double commitment for the doctor: to betray *neither* his patients *nor* his own professionality.

Sigmund Freud described psychoanalysis as a love cure. That cure would only be possible if there is a repressed love in the patient behind the suffering, behind the psychic and psychosomatic symptoms, the despair, helplessness, mourning and fury. It is important to recognize that this is the most common reason for people looking for psychotherapeutic help – but not always. Love is also crucial for the psychoanalyst/psychotherapist: his/her professionality, intuition, and psychological knowledge should be steeped in a loving – *arglos* – intention, a constrained passion, which will facilitate a non-intrusive examination of the patient in cooperation with the patient. This is what Balint called *a mutual investment* *company*. Correspondingly, would you not agree, that love, the *arglos* benevolence, is necessary for good enough doctoring?

Such personal qualities and professional motives should not be taken for granted in clinical practice. They may lack, or more often be blurred by, other motives and psychological and social restrictions. Correspondingly, we should not assume that the motive of patients seeking therapeutic or medical help is *always* benign. As a Balint group leader, I have been struck by how many hard-working doctors in various somatic specialities *do* have these qualities and professional motivation. Many of them are psychologically resourceful – a gift often not recognised by themselves until they discover it through Balint work. Then they can make better use of it in their clinical work. It is easy to understand why Balint wanted to work with such colleagues. They certainly must have widened his perspectives, just as Balint group work opened new areas for applied psychoanalysis. A mutual investment company, indeed! Michael´s namesake Stefan felt the same (see footnote 1).

Balint (1952) coined the concept 'primary love', describing the early mother-child relation – the harmonious mother-child mix-up – an area characterized by a powerful mutual illusion, out of which the individual will gradually emerge.[3] From here the child will discover the world, its own creativity. The impact of the mother-child mix-up experiences – to most people deeply embedded in their childhood amnesia – will have a considerable impact on our adult lives.[4]

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[3] Reading Balint´s books and essays, you can really sense his vitality as a psychoanalyst. Yet, as Harold Stewart (1992) pointed out, Balint did little to link his ideas to other contemporary psychoanalytical theories. Balint himself wrote that it was due to his lack of courage. I could not possibly know but I have an impulse to disagree. I think he had good reasons, like avoiding involvement in the Melanie Klein-Anna Freud controversies. However his thinking and concepts, particularly on ochnophilia and philobatism (Balint 1959), and also on more accessible ideas like primary love, creative area (Balint 1952), basic fault, etc., were never quite integrated into the psychoanalytical mainstream, despite their obvious connection with Hermann, Mahler, Ferenczi, Winnicott, Freud, Little, Bion and Fonagy.

[4] Balint tended to see traumatic experiences as affecting the primary-love state of the baby – threatening to damage the development of the child's budding loving capacities – rather than focusing on primary rage and hate in a baby who is experiencing external 'normal' frustrations. His

My reading of Balint is that he saw traumatic experiences as something that was threatening to the primary love state, the creative area. Traumatic experiences, mainly in the preverbal stages, could prevent the development of the creative and loving potential of the infant. The harmonious mother-child mix-up would be a reasonably safe harbour, a container, for the painful, overwhelming, and terrifying experiences of the world into which the baby so recently had entered. Primary love in the mother-child mix-up would help the child to gradually incorporate, assimilate, and integrate the world and thus develop increasing independence.

Internalisation – the incorporation of impressions, experiences, relations – is a process which starts very early in life, presumably in utero. The differentiation between self and object emerges gradually. A prerequisite to mourn someone/something is that it must be represented in the inner world of the mourner. Our ongoing everyday lives are played out in parallel spaces of our souls. In most of us, fortunately, there are some leaks between the universes of fantasy and reality; between obsessions and passionate ideas on the one hand, and reflective thoughts and calmer states of mind on the other. Balint (1952) spoke of the *creative area*. We could see these parallel states of mind as the living heritage from our childhood fantasies, which become more or less integrated and more or less repressed in the adult ego.

D. W. Winnicott (1971) developed a similar concept, *the intermediate area*. Similar to how a child enters into relation with a stuffed animal, or a snuff blanket, or various forms of imaginary or interactive playing, the grown-up enters into relation with the drama, worship, and nature. And to his fellow human being. This

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thinking is concordant with Winnicott´s 'good enough mothering' and Bion's transformations of indigestible psychic elements into digestible ones. The harmonious mother-child mix-up setting will contain frustrating and traumatizing experiences and, in the end, promote separation, individuation, and growth. Balint stated explicitly that every psychoanalytical theory – including his own – contains a basic-fault bias, urging us to spot it when judging the essence and clinical relevance of a psychological idea. What I am missing in Balint´s discourse is a discussion about the possibility of a mother-child disharmonious mix-up and the constitutional potential of the baby itself, i.e. its ability to cope with disharmonies in early-symbiotic relations.

is what Martin Buber (1937) named the *I-Thou* relation. These concepts embody a psychic reality, which may help us to deepen our understanding of our clinical practice by looking at the surgery *also* as an intermediate area.

Would it be fruitful to consider that we offer our surgeries to our patients not only as a clinical meeting place but also as a personal playground – a place where we are playing, but also are played on and played with? The meetings with some patients, some situations, for better or worse, tend to touch early strings, increase the permeability between our parallel inner worlds. How do the inner perceptions/images, which doctors and patients have of each other, match with actual psychic realities? From a strictly medical perspective, I think it is important to recognise that these more or less conscious biases do at times affect clinical judgement significantly. Balint´s (1971) concept of *the apostolic function* links directly to this transference by the doctor onto his patients.

How do we affect each other in more or less harmonious ways? How protected, or unprotected, are we as doctors in those meetings? Where does mourning enter, and what is its place? The practice of any somatic doctor differs from that of the psychoanalyst. But still, personal basic faults projected on patients do affect the treatment situation. Doctors live in a 'harmonious and dis-harmonious adult mix-up' consisting of an uncritical obedience to the local subculture of the clinic, to EBM and other guidelines, and to the influence of the pharmaceutical industry, leading to over-medicalization, which exerts a strong influence on the doctor-patient relationship.

Depression and Mourning

Freud (1917) emphasized in his essay on 'Mourning and Melancholia' that mourning consists of psychic work on an object loss. Depression is similar but different. Mourning is painful and exhausting, but, Freud stated, it does not significantly affect the self-esteem of the mourner. The purpose of mourning is to liberate the love of the mourner from the lost object. Let us say that someone we love *is* dead. The full implication of this sentence is a psychic contradiction as the immediate reaction tells us that someone we love *cannot be* dead. Reality tells us that we cannot be where the deceased loved one is, but the bonds of love oppose it, by spontaneously refusing to accept reality. Sometimes the mourner has a strong urge to join the deceased loved one. In the *work of mourning* (this Swenglish expression with its association to labour is more expressive than the *process of mourning*) the presence and the memories of the lost loved one are intensely reactivated. Thus, gradually, the bonds can be eased. The mourner can move on. The deceased loved one does not exert such strong pain inside the mourner any longer. The dead is not part of a shared life any longer, yet is alive, incorporated, in a different way. In Swedish there is a saying about a person full of zest and vitality: 'He/she is full of the bones of the dead'.

The most significant difference between mourning and depression consists of the 'inner right' to liberate oneself from the lost object. A depressed person constantly lives in the shadow of the lost object, Freud said. The depressed person is often clueless about the feelings and thoughts that are dynamically active in the depressive process. The affective life is dominated by hopelessness and meaninglessness. The sense of coherence is fragile or lost.

As doctors it is unavoidable that we meet with patients and relatives and are thrown into situations that affect us. Most doctors are committed to deal with them one way or other. (Some are not). Doctors who do not have the space to reflect and work on painful clinical experiences are under oppression and run a risk for secondary traumatization. The cumulative *unresolved* experiences – recognized or not – tend to lead to chronic unease, personality deformities (detachment, cynicism, hyperactivity, obsessiveness, etc.) – and/or depression. The consequences, neither for patients of such doctors nor for the doctors themselves, are not difficult to imagine, if we allow imagination a minimum of space.

Repressed Mourning

Over the years as a Balint leader, I have often wondered how many doctors there are out there who are clinically or sub-clinically depressed from harbouring introjected clinical experiences chaffing in them. ‘Where on the VAS-scale is your case?’ That is a frequent question when setting the agenda for a Balint session. The doctors themselves usually underestimate the pain and the urgency of their cases, whereas in a well-functioning group the other members can hear the pain and distress of the presenter already in the first sentence.

The situation for a colleague presenting a distressing case often reverberates with a state of inner loneliness where doubt, self-reproaches, and self-devaluation dominate. Working through your case in a Balint group is greatly facilitated by the other group members making themselves available as living and present objects, as temporary auxiliary egos for the presenter. Indeed, the entire group can be seen as a good-enough mix-up. By being immersed in in it, the presenters may recover and develop a more distinct, and a better integrated, professional ego. They will be able to reflect on the doctor-relationship in a more realistic way and have a clearer view of its intricacies. The patients will gain a more available doctor. It is similar to adult patients who successfully work through a depression in therapy or analysis, and whose children will gain more present and adequate parents.

There is another parallel between Balint group work and psychodynamic therapy or psychoanalysis. It happens more or less often that you as a therapist become aware of your own unresponsiveness to your patients. Such deficiencies and defects in the therapeutic relation can often be repaired and turned into something useful that will help the patient come closer to himself. It may well be that the therapist was absent-minded or insensitive 'on his own merits'. But it may also be that something in the patient´s inner life was subtly enacted in the room, affecting the therapist in the therapeutic mixed-up relation. This process would then be understood as a return, in the here and now, of a traumatizing process in the life of the patient.

In a Balint group, when a colleague is presenting a case that profoundly affects him or her, we are facing a parallel situation if we are not responsive enough. Presenters may even be unable to grasp the insufficiencies of the group. This is a situation resembling work on the basic fault level (Balint 1968). Usually, presenters withdraw into polite numbness. Even if they are vaguely aware of the discussion being misdirected, it is difficult to criticise well-intentioned colleagues when you are at a loss yourself. But, if group members become aware of their failure and the effect it has on the presenter, we may address it. Compared to the setting of individual psychotherapy, there is the advantage that, in a well-functioning Balint group, there are more persons who have the potential of adequately addressing a tormented colleague. Someone will be able to see through the mist. In the end, it is the responsibility of the leader.

Freud (1915) wrote in his paper 'The Unconscious' that a (traumatizing) external stimulus could be internalized, 'i.e., by eating into and destroying an internal organ' – a challenging proposal for psychosomatic medicine. I suggest, in analogy, that undigested clinical experiences are a kind of external stimuli that may be introjected or internalized in the doctor and stay undigested as a painful, shameful, guilt-ridden memory, or a symptom – depression, anxious tensions, and psychosomatic symptoms.[5] Introjection implies that the experience is insufficiently contained mentally. It is analogous to the traumatic experience of the child, when the harmonious mother-child mix-up has failed to contain and protect.

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[5] Such an internalised stimulus will act like an instinctual impulse: it creates a state of tension, discomfort, and pain. Freud (1917) returns to the theme of pain again in 'Mourning and Melancholia'. He views the depression that consumes the melancholic person's self-esteem as a process functioning like an instinctual drive. In psychoanalytic work we can, in favorable cases,

Clinical Application

In many doctors, professional maturation can also be seen as a mourning process – conscious or not – the lost object being their youthful ideals and visions about the profession. Clinical reality is ‘naked’. Meeting with dying and seriously ill patients and their relatives, and facing self-destructiveness and social misery may wear heavily on doctors. So does their meeting insensitivity, cynicism and brutality in colleagues and staff members. Even very experienced doctors can be taken off guard. As discussed above, the burden of guilt is an important dividing line between mourning and depression. Not having lived up to one´s own standards, whether real or fantasied, and particularly when the outcome is fatal for the patient, may precipitate a depression. Balint work can transform such states into sadness.

I think it is important to keep Martin Buber´s (1937) distinction in mind between existential guilt on the one hand and feelings of guilt on the other. Guilt for one's actions that have affected others can never be ‘treated away’. They must be acknowledged with the guilt and sorrow that they entail and with those reparative actions that may be possible. One particularly important aspect inherent in Balint work is that you can learn from mistakes by not denying or trivializing them. But, as Buber said, feelings of guilt do not necessarily imply existential guilt. In Balint discussions we also discover that conscientious doctors have internalized

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revive, rediscover, and reconstruct traumatizing object-relations. The ideas and processes underpinning the depressive state can thus be differentiated from a person´s instinctual life. Indeed, psychotherapeutic work with depressed persons is similar to labour, the therapist acting like the mid-wife.

the imperfections and shortcomings of their clinical environment, thus becoming its victim, following the pattern that 'The shadow of the object falls on the ego' (Freud, 1917). (One should add that doctors who become the active accomplices of a flawed clinical environment are often unfit for Balint work as reflection precipitates too much conflict, guilt, or shame.)

Relief and catharsis are a vital part of Balint group work. Presenters may say that a heavy – and sometimes long-standing – burden has been lifted off their shoulders. But exploring deeply rooted personal idiosyncrasies that affect clinical work (apostolic functioning) is a much longer process. In my view that is a more important and challenging aspect of Balint group work (see Courtenay, 1977, 1992; Salinsky, 2018). Grief and depression may also be reminders of irreplaceable losses – sometimes manageable, sometimes not. To what extent have we chosen the medical profession with the intent to repair something that cannot be repaired inside of us? If so, how does that affect our apostolic mission?

Clinical and Balint Group Examples

A respected and somewhat feared anesthetist, with a few years left until his retirement, breaks down in tears while talking about how he lost a middle-aged patient whom he failed to intubate 35-40 years ago. As he talks about the meeting with the patient and the relatives, and his own vulnerability and loneliness, there is a feeling that it has recently happened. His boss, a benevolent, non-judgmental man, had been unable to meet him in a deeper collegial sense. He had come down to the room with the young doctor and the dead man, taken the laryngoscope, noted how difficult it was to find the lumen, and then with a slanted laryngoscope, kindly and educationally: 'Come, look, this is how you could have come in.' The rest was silence. Our devastated colleague had not been able to go to the clinic for a week and had to take a very long professional detour to be able to return to the specialty he was *so passionate about. He brought the case both for his own sake and because he wanted to give something to his younger colleagues in the group.*

I thought that he was brave. Considering his position at the clinic, he took a risk with his younger colleagues by exposing himself. But the Balint framework – equality and freedom of expression – was obviously safe enough.

The emotional extremes in clinical everyday life can sometimes become too much and create conflicts, i.e., if the doctor´s own spontaneous zest for life threatens to break into in the clinical work.

This is exemplified by a presentation by a colleague at a G&O clinic – an unrecognized emotional roller-coaster experience until it was brought to mind in the late afternoon Balint session.

In the morning:
A number of outpatient abortions
Then a visit to the maternity ward
Lunch
In the afternoon at the outpatient surgery
Neonatal death follow-up with a couple
Then a couple consulting on involuntary childlessness
Then a couple wishing abortion, quite late, appr. 16th week. With an ultrasound, I examine the couple wishing for an abortion and I have a spontaneous urge to exclaim, 'You have twins!' I have to bite my tongue. I am at a loss. What is this about? I have nothing to do with them. They are requesting abortion and my duty is to comply. Do I sense ambivalence? In her, in him? Or is this an after-effect with me from the previous visits? Or being tossed dealing with fertility and infertility the whole day? It is helpful to have a Balint group to sort things out to avoid stress and confusion.

This final example illustrates Balint´s thoughts on the vicissitudes of human psychological development and early attachment reflected in a Balint group case. I believe that in some Balint group presentations I can hear the doctor making him/herself available to his patients with something resembling the harmonious mother-child mix-up.

The connection between early attachment and clinical presence is rarely explicitly thought of, but I often find that there is an echo of it in the good clinical encounter. (There is a saying in Swedish 'Health remains silent', yet psychoanalysts insist on bringing those states out of their silence by giving them names). In Balint work, we focus on the clinical here and now – we do not put our group members on the psychoanalytic couch and ask them what associations they have to their childhood and other personal experiences when they meet with their patients. This means that the link between the acute strain and grief reaction of the doctor in a particular clinical event and its connection to the private sphere is usually unspoken of and only implied. Yet it can be seen and confirmed in the group. Though it is not in focus for our work, it happens that personal experiences spontaneously are told.

The presenting doctor in a mixed specialty university hospital Balint group has been treating a severely chronically ill patient, in his forties just as herself. He tries to keep up his family life and work despite his disease with impending organ failure which requires frequent hospitalization. That is when they meet. His state is gradually deteriorating. There is a silent rapport between the doctor and her patient, the doctor explains: 'I cannot say what it is. But there is something special about the character of this man, and yet there are so many things about him that I do not know anything about.'

It is winter. The doctor is off to the Canary Islands for two weeks of well-deserved holidays with her husband and children. She enjoys it thoroughly and sleeps like a log. In the second week of her vacation, she suddenly wakes up in the middle of the night thinking, *'He is dying right now'. Back to work the week after, she finds out that the patient had died in the very hour of her awakening.*

There was a long silence in the group after our colleague had unburdened herself of this experience. Gradually thoughts were shared. Her awakening that night and her uncanny feeling seemed to some group members as a natural consequence of what she had told. Some recognized the situation and feelings of the presenter and were reminded of having similar experiences of their own. Others were moved as if a new landscape had been opened. The wordless sharing was an important part of group work. The presenter had both created and found the place to mourn and re-experience what her patient and his dying had meant to her.

On an unconscious level it would seem as if the doctor and her patient were connected in an early mix-up, a sharing within joint boundaries. The group in silence also seemed sufficiently able to share and work on that level. On a *conscious level* there was no manifest mix-up, just a good, friendly, respectful relation between individuals for doctor and patient, and as a parallel process as the discussion evolved in the group after the silence.

Many doctors tend to disregard sensitivities like these as they may be perceived as uncanny (or *unheimlich*), irrational, and certainly at times very tiring particularly with severely ill, deteriorating, and dying patients. The Balint group is a unique place where you may discuss and reflect on such aspects of clinical work and turn such personal qualities of the doctor into a clinical tool.

I think it might be helpful to recognize that human exchange is affected by such undifferentiated, 'primal mix-up relations'.[6] The impact on the doctor-patient relationship varies of course but may be considerable.

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[6] For instance, those psychoanalysts who are not aware of how their own basic faults affect the analysis and refuse to address this problem (for narcissistic reasons, or to avoid personal pain or guilt), use their patients and the psychoanalytical body of knowledge to reinforce their own narcissism and to avoid a real life. Both Ferenczi and Winnicott recognized the desperate need of

Some six months later, this colleague presents another case. She told us that she rarely got involved in the treatment of children, but now it had happened.

I don't remember the details, and it's immaterial, but her pediatric colleagues needed her specialist expertise. They had first involved her by phone but eventually she had seen the patient, a seriously ill child, a couple of years old. She had given important advice and instructions to the pediatricians but was completely devastated. In a low voice, she says something like this:

'I had intended to become a pediatrician myself, but my first child died. I was a young doctor. I knew there was something seriously wrong. I searched, I inquired, I tried to explain. The doctors didn't listen. I have tried to tell myself that it was difficult, but I´ve had a hard time getting past the fact that it took them such a long time. And then it was too late. It might have been too late anyway, but I've always thought that, if they had listened, she would have stood a much better chance. I chose this line of service so that I would never again have to face a seriously ill child. '

To me, the atmosphere in the group that shared the experience of our colleague was like being present at the funeral service of her child. In hindsight, I was thinking that the sensitivity she had towards her dying child was transferred to her patients, such as the man with the liver disease. But these patients did not give her an immediate reminder of her own dying child.

Concluding Remarks

Many colleagues suffer from not receiving a positive or negative response from their patients. This tends to affect the self-assessment of their professional contribution in a negative way. The absence of emotional reciprocity – the illusion

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the patient to cure the psychoanalyst – to create a mature and useful helper. This reflects how a baby plays an active role in establishing the mother-child mix-up from early on.

in the mix-up sense described above – is a pathway to depression. Being structured and ‘moderately shielded’ can be part of a professional adjustment strategy. But shielding and blind obedience to standardized procedures might prevent doctors from being clinically present and from finding appropriate solutions in an interaction with their patients, which will affect both patients and doctors.

Let us not idealize the medical corps. Some colleagues lack the inner resources to deal with this kind of professional stress. Some defenses are therefore just as rigid as they are necessary for the individual doctor. But I guess that at least half of the members of the medical profession can cope with the pressures inherent in Balint work – i.e. critically and benevolently reviewing one's own clinical practice. The longer you delay such a process, the more difficult it becomes. Because whatever the doctor is made of, too many unprocessed impressions in clinical everyday life risk numbness and dullness. In the clinical meeting there is the seed of a mature professional attitude, but also the seed of destructive action. The doctor can direct this towards his patients as well as towards himself. Declining professional self-esteem, alienation, confusion, poor judgement, burnout, cynicism, and withdrawal are not only symptoms in their own right. They may also be seen as expressions of defenses against anxiety, sadness, and fury with regard to our shortcomings incorporating and internalizing the conditions and fates that we encounter in clinical everyday life.

In a focus group interview that Elsa-Lena Ryding (2023) did with Balint group participants, an experienced colleague said: ‘I don't know about the rest of you, but I think it's good for doctors to air their concerns. In the 19th century it was said: “Doctors and priests bury their dead together”. Pretty good! Today we also need to bury our sorrows and difficulties… together!’

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