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The Use of the Group Leader's Countertransference in a Balint Group

Gearóid Fitzgerald¹

¹ Former President of The Balint Society UK: gearoidf@gmail.com

I would like to thank the Severnside Institute and Judy Malone for asking me to talk today. It is a real pleasure: I am giving this talk in the hope that we may have a discussion about two overlapping but distinct theoretical strands.

For me there is a paradox in Balint groups. We focus on an emotion or impression of one in the presenting clinician as one of the major items of importance in the consultation. Yet, in a Balint group, we rarely talk about the feelings evoked in the group leader as of any use to the process of understanding that clinician-patient relationship, nor do we talk a lot about the overall emotional atmosphere of a group. I view Balint groups as an application of psychoanalysis, but Balint Groups have a particular body of theory that leans on but is different to doing psychoanalysis, and is definitely not like an analytic group.

This interest has developed in time after a number of Balint Group Leadership workshops in London and weekends in Sligo. There was one person in particular, a Group Analyst from South Wales, who brought it clearly into focus for me: a number of people were commenting on what might be seen as a 'parallel process' in groups (i.e. where somehow the group process or the presenter parallel what happened in the actual consultation with the patient without realising it). They felt one might intervene by describing a group process to the group along the lines of: 'I think the group is doing x or feeling x'; and linking this with the consultation. It is an absolutely acceptable stance and I imagine it can be used creatively. My heritage, however, like that of Michael Balint, is psychoanalysis and its theoretical constructs. It is from those that Balint groups originated. I began wondering how one can theorise this in Balint terms. And how one can conceptualise the fact that the Balint Group Leader is not immune from feelings or from acting out in various ways on those feelings.

¹ Dr Gearóid Fitzgerald is former President of The Balint Society UK and a Balint leader for over 20 years. Psychoanalyst in private practice. Formerly Consultant Psychiatrist in Psychotherapy and Training Programme Director for Psychotherapy Yorkshire and Humber region.

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An example from a group always helps me think about these issues.

This is from a fortnightly group of SpRs² with 8 members on this occasion and a mixture of psychiatric specialities. The doctor who said he would present is an experienced adult SpR. He tends to mumble and speak quickly. He said what had happened with this patient troubled him and had made him angry. Two months before, he had been called to see a middle-aged male patient who had been found on a bridge and brought in by the police for the second time. He described how the crisis consultant had filled out the section form and said to staff: 'If doctor x doesn't make the recommendation then that's fine'. But he went home and never spoke with the SpR. The man didn't say a lot except the he was going to kill himself. He was somewhat aggressive and bullying. They got very little information. He had been seen the night before and the SpR had not sectioned him. Then he had been a lot more bullying and threatening behaviour. He had signed the form to section the patient, as he felt he couldn't take the risk not to. He had felt angry and had followed up what had happened with the patient. He found out he had a court case the day after and was facing a prison sentence. He moved from another city and had no friends. The doctor said he had been appalled that the patient was still there and had been to PICU without a diagnosis being made. The ward consultant whom he had expected to discharge the next day was treating him as depressed.

Some desultory questions followed, and then the group launched wholesale into a shared conversation about being put under pressure by the consultant, being put in an impossible position. The group spent some 10 plus minutes talking about the system, its inadequacies and its impact on them. I had a whopping countertransference of fury and a sense of them being cowards and blaming the system. One thing about countertransference in my opinion is that it is rarely about feelings one is comfortable entertaining. I let them talk because I knew if I came in

² Special Registrar.

I would convey something very critical in my tone. I eventually said that I wondered if the doctor liked the patient. He said he had disliked him, he didn't know why but he thought he was horrible. Some people spoke about him being a psychopath. But there was no effort (unusual in this group) to speculate about the patient's feelings. They went back to the pressure they felt under and how impossible it was to take a risk. The presenter chipped in with talk about defensive medicine and his career and they all spoke a bit about this. They were in agreement: 'This was how it should be'.

I had struggled throughout the group not to become one of those sad old consultants who says things like: 'In my days...'. I did find it hard not to be swept away into a hectoring stance towards the presenter and one group member who was particularly vocal about the patient and the consultant. I eventually said that I had wondered how the other SpR of the night before had felt able to do something different in the face of all these realities they had been describing.

The conversation continued a bit as before then one doctor said he wondered how the other SpR had managed it and they paused. A number of appeasing solutions to their agreed viewpoint were offered. One then remarked it is hard to take risks, but maybe the other had felt more able because of seniority. The presenter said with some surprise that usually he could but this time that had felt impossible for some reason. Just not possible. He then remarked he had disliked the patient so much and he seemed to sum up what was wrong with psychiatry; why was he seeing someone with no mental illness.

I said it did seem like he was describing having to risk-manage this patient only. I tried to lead the conversation away from a general one. He nodded and said he felt ashamed actually at what he had done and then baffled as to why the consultant kept the patient on the ward. And angry. So angry. This was very unusual for him he said. The member previously mentioned reverted to 'the system' and how cruel it was to her and the others. I could see they were about to

go off again and I said maybe could we think about that this doctor had said at the beginning: he would be finishing his training and maybe with this patient he was also thinking what would he do as a consultant when the buck stopped with him. Silence and irritation, I thought. Then the presenter said: 'I worry about having to take these decisions as a consultant as I feel there is no support from the Trust but I also suppose I was ashamed of myself here and frustrated with myself at not being able to do what I knew was right and was my opinion'. Then there was some sadness and talk about how the patient had intimidated the doctor or tried to control him. He agreed that that was how he had felt but couldn't get at it then; instead, he had just felt really angry and wanted to lash out at this man in a way to really punish him. Then it ended.

My reflection on the process of this group would be: the hidden feeling for both the doctor and patient may well have been one of shame and humiliation at the position they find themselves in and their powerlessness therein. Both are hard wounds to one's sense of self to bear and very painful feelings. My impression was that the doctor felt more and more ashamed of himself, but that was the painful feeling he had to be left with, to do with as he could. Anger and outrage projected outwards are defences against those more painful feelings. Now my job was to bear and play with the feelings I had to try and metabolise them to get to a position where something split off could be kept in my mind and eventually I could say something where a more open possibility might arise in the group.

There are many things in this group which I could focus on. This group usually works well and creatively together. Yet, on this occasion, the group went away from that usual pattern. How do I understand why I was under the sway of very strong feelings for the majority of the group and struggled to be benevolently thoughtful? It took me very long to remember this was a group that worked well not a group of cowardly self-serving creatures.

Enid Balint once made the point I think that Balint groups are essentially countertransference groups. But how do we make sense of that for ourselves as leaders?

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I would like to draw on a few basic orienting quotes from Balint.

Balint groups and seminars are guided by simple and elegant concepts: 'this is to examine the relationship between the doctor and the patient, to look at the feelings generated in the doctor as possibly being part of the patient's world and then use this to help the patient. If these feelings do not seem to belong to the patient but to the doctor it helps to know that too, to be a participant in a relationship and its observer is fraught with difficulties and potential bias. The aim is to study this (bias) carefully. As a consequence, the doctors can take the feelings that arise from their work seriously and pay attention to much that would otherwise be disregarded' (Balint, 1964).

The Balints were the first to introduce the idea of the participant observer into the area of clinical medicine: 'whenever doctors use their feeling as a tool as a personal internal barometer, they open themselves to the kinds of error to which any instrument is prone. What troubles the patient may be obscured as the doctor picks up other sounds, they may arise from inside the doctor patient interaction or they may be extraneous.' There are various psychoanalytic constructs that underline this idea theoretically, the main being the transference and countertransference.

If one listens carefully to the feelings that are presented in the telling of the dilemma, one might get a sense of what is going on in the doctor-patient relationship, hidden out of view. I think this is very clearly picked up in the emotional tone or atmosphere of the consultation which can be communicated to the group and become the group atmosphere. It then influences the subsequent discussions and feelings. The countertransference of the group leader might be

described as feeling the subtle unconscious ways we are pushed to re-enact and react to formulate scenarios with our groups that come from the patient's past, or the presenter's conflicts, or group member conflicts, or our own conflicts and biases.

Technically you could see Balint groups as countertransference groups. I find for myself that my countertransference feelings orientate my interventions much more than the verbal material. It may determine the selective facts I pick up to intervene on or the tone or the way in which I intervene.

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I would like to look theoretically at both the notion of countertransference and the notion of what we might be doing as Balint Group Leaders in a Balint Group. Here, I want to acknowledge a debt of gratitude to Jane Dammers, who, as President of the Balint Society UK, was very gracious in encouraging my view that, as leaders, we had to have a dialogue with theory and see to its evolution in order to conduct alive Balint groups.

If I think about countertransference first, up until 1950 Freud and Klein had both held the position that feeling strongly in consultations, or feeling at all, was a deficit in the analyst. The analyst should go back and explore what it was about. And so the idea of neutrality was idealised and paramount. In the 1950s, in Britain, Paula Heimann wrote that actually analysts in consultations did have feelings and they could be of use. I think both are very important to think about theoretically. Sometimes the analyst or the Balint Group Leader can have a personal countertransference, a reaction against a transference in response to the group, that is the analyst's personal conflict zone or one of the analyst's personal conflict zones. That is one type of countertransference. It is literally transference to the emotional goings on in either the patient or the group or a particular group member. That is one that needs a particular form of thinking about as the analyst or group leader will contaminate the group if it is left un-metabolised or acted out. In this group I

have to wait to figure what it is about one particular group member that I so dislike that I act out by overcompensating and offer every benefit of doubt to them.

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What has taken over in people's thinking is that countertransference is always of use in thinking about the patient. All these have become a bit clichéd. One error is that everything has to do with the patient; this neglects the fact that in any countertransference there are conscious and unconscious elements. One has to do quite a bit of work to get at what might be the underlying conflict or feeling rather than just taking the surface feeling as what is going on. There is a story that I am not sure is true about Klein, but I certainly have been told it in the British Psychoanalytical Institute. Somebody went along to her and said 'I felt sick and the patient was making me sick' and Klein said 'No, no, my dear, that's indigestion'.

I think she was making a very valid point that actually one shouldn't confuse what is yours with what is the patient's, and if you start to feel something in the process of professional activity then one has to feel foremost, and then think and work at what it is: what it might mean and how much is one's own and how much belongs to the scenario that you are involved in, be it a Balint Group or individual work with a patient. Irma Brenman-Pick wrote a paper, 'Working through the countertransference', and then a second paper 'Further working through the countertransference', because she was concerned by the fact that everybody was taking a linear view of what she was saying that if you feel what the patient has put into you, that is working through. I don't think that that's what she meant, there is something way subtler here. What is implicit in the British Psychoanalytic tradition at the moment is that the feelings in the analyst, therapist or Group Leader may indeed be very important to the split off parts of the patient and subsequent projective processes that are happening in the room. It is the job of countertransference work to get at what might be happening in that. The other possibility of course is that one can act it out without knowing it. It is my stance

that there are always unconscious processes going on. There are some situations where one is trying to catch them and let them come to the fore, and then let them be elaborated and worked through. That will then lead to a greater understanding of either yourself in minor key, but more importantly to greater understanding for the group/person with whom you are meant to be working with. Therefore, this work is done in the service of the patient. I think it is about letting oneself entertain the feelings and associated thoughts and ideas, but keeping them in the position of potentials, which is very similar to Balint idea of the participant observer stance. To be in it and not taken over by it is the key.

I have noticed two things in thinking about Balint Groups. One is that we are told a story in a Balint Group about a certain doctor with a certain patient in a room, sometimes with a family involved, sometimes with a team involved, and they are part of the story. A second thing to notice is the atmosphere that is created. I have noticed in groups that frequently it is the atmosphere that is never commented on, never thought about as having merit to the doctor/patient relationship. Certainly, the thing that is almost never commented on, no matter how obvious it is, is the attitude the doctor demonstrates to the patient non-verbally. By this I don't mean how they sit and how they look and make eye contact. I presume that's part of it, but GPs are pretty tortured by these things in terms of their video supervisions and so on. What I am talking about is something more subtle in the way they use words and the tone of voice and the emotional tone. They conjure up something about the atmosphere and the situation.

This, I believe, has an impact on the group and because we are in the presence of these very sophisticated youngsters who want to convey that they are not that sophisticated. The idea of saying what you actually feel or what you actually think is not common at all now in medical education and it is seen as a bad thing: all speech has to be very bland or correct in a way. My consultants keep saying, for instance, 'a 43-year-old lady/gentleman...', so a large part of the group

is frequently getting through formulaic phases, like challenging or frequent attender, or a rationale stance with patients, even if they are obviously troubled. But what happens when the group is happily caught up in an agreement on what is happening with the doctor and the patient, while the Group Leader has a very different impression of the consultation? This is the case in my example. The group leader is sitting with feelings that they consider part of the consultation, but which have been – if you want to be technical – split off and projected into them. It is a very difficult situation because you might not have any material in the group to comment on, but at the same time somehow you have a bit of a conviction that something is being omitted. One can be left, or saddled with an odd set of feelings.

For me the first step in thinking about my countertransference is a developmental one. I have been a Consultant for 23 years now and am coming up to retirement. I have got to be careful that what I think isn't necessarily what's happening because I am not at the same developmental level as these junior doctors are and introducing something too far ahead may not be in any way helpful to where the group is. Some Leaders are very silent and let the group go where it goes. I think that is admirable and something I've never managed myself. Other people feel it is quite important to reintroduce into the mixture, in some tactful way, the possibility that something might be missing from the group and I think it is important. But the question is how one does that.

Countertransference is not a neutral thing: a lot of the time it is manageable and you metabolise it with some effort, automatically and sympathetically. But there are other countertransferences that demolish sympathy for the presenter or for the group and one is invited into a very different emotional territory. I see it much more in the 'paranoid-schizoid position', but one has to struggle with very strong judgemental harsh attacking feelings. This may not happen with everybody – it may be part of how I deal with it – but then one has to be very thoughtful about what one might say and how one might say it. Frequently it comes out in my tone.

Then one is left with a group of young people who have been told what to do or grandstanded at by a senior Consultant and it stops all creative discussion. They are much more likely to comply and go down that route, but not really learn anything because actually where they were going is not where I was going. At the same time, the place sometimes where they are going is not a place where they should really spend too long in, but you might need to let them spend some time in it to move on to somewhere else.

I am thinking here of Esti Rimmer's paper on the containing function of a Balint Group Leader. If one has sufficient trust in the process, then one might think: 'Well, this is going to come out at some stage', and one just waits. I think the problem with trainee groups is that they are not coming to you for long enough. The Foundation Years come for four months, the Core Trainees for a year. The Specialist Registrars come for three years, so this does give you a chance to sit back and see what evolves.

The first step in any dealing with the countertransference is to try and see what sort of narcissistic investment one has in what one is feeling and, in particular, how much one adopts a subtle high moral ground or a subtle 'Let me demonstrate to you where I am at' stance. Whenever I detect that in myself, if I detect it in time, I shut myself up and try and wait. Frequently, that effort of waiting is worth it and usually something comes out; or my co-leader will come up with something more thoughtful and more benevolent. There are times when one isn't able to last. There are other times when one can get hold of something and the question is how does one tactfully introduce it as a possibility, rather than introducing it as an instruction from a senior person. How does one introduce the idea of opening up the space for wondering when one might be very far from that space oneself?

I have found that the easier set of feelings to deal with are the denied or disavowed negative feelings that young doctors bring to groups. I have found that if one can, in a kind of neutral way, realise that there is the possibility of negative

feelings and that they are not terribly bad, one can introduce them. The group members tend to run with that and there tends to be an ambivalent discussion. I think the outcome of a good intervention is to get both sides of a possibility explored and not sorted. I don't feel I am forcing something, I do genuinely feel like there is something that they are hinting at, that they want to discuss, but that some part of them cannot allow it to come in. Sometimes if one needs time, if there is a particularly brave member, they might bring it up. One can support them a little bit and support that possibility.

There is another set of feelings about tenderness and sexuality. They can be split off, and one has to keep aware of difference. The difference in race, culture and sexuality. Sexuality is a particularly big one because it is one that people tend to underestimate quite a bit. I am not saying racism is over-estimated, I am just saying it's the one people don't tend to think about in partnership with the doctor/patient relationship and linked with sexuality in a more ordinary way. A fact to consider is that you have young doctors with young bodies and young minds and young healthy attitudes to things usually (or not), who are in a room with people who are either physically ill, or mentally ill, and who haven't had the same trajectory as them. One has to keep in mind the possibility of the patient being envious or jealous of them and of that envious feeling influencing the consultation.

I think doing groups with trainees/medical students requires a slightly different application of the Balint Leader stance. I find I talk more and describe what might be happening in the consultation or in the realm of feelings much more. The aim is to free up something, particularly in the realm of feelings that can't be spoken about, but are implicit in the way the consultation is being described or in the material of the consultation. That intervention may allow them to begin to play a bit more and free-associate or say more honestly what's on their mind.

He describes the listening required of the clinician and the similar task of the leader. Both are stated with the admirable simplicity and brevity born of long thoughtful experience. He pinpoints accurately that it is this listening to the language of the unconscious and saying enough to open up something potentially new that is important. It is not interpreting or translating, on the part of the analyst/Balint leader, into clever interventions or phrases that is essential, but more an openness to not teach or suggest, to wonder about something that strikes them in the emotional atmosphere of the case and the doctor patient relationship, and the way the story is told and received by the group.

He is kind and, I think, respectful of the fact that analysts are trained to especially listen for and to the unconscious but also clear that it isn't a preserve of psychoanalysts. In Balint groups, it is something one can develop and refine with the help of properly trained leaders and contacts with interested psychoanalysts.

Today there are a number psychoanalysts involved with the Society and trained as Balint leaders, so we are once more in a position where a new fruitful dialogue about listening might take place. This time I think it might be with psychiatrists in the main and their clinical work though hopefully more GPs will re-find Balint.

This paper would be helpful to the many people who lead Balint groups who have not had much contact with trained leaders as it gives them a clue as to why it's important to maintain the links with psychoanalysis and the language of the unconscious.

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