Balint groups: place and space of knowledge of the sickness as experienced in the operator-patient relationship

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Abstract

This article contains insights and considerations by the author on Balint groups, and especially on the therapeutic relationship between the operator and patient. In the group, the doctor uses himself as a "drug" and while the speaker speaks of a clinical case experience, relives this story in the hic et nunc .
The group leader and therefore observe the countertransference of the speakerand therefore the group has three dimensions: the relationship with the patient, with the leader and the group.
The disease is then reactivated by the experience of body-group in the hic et nunc.

Keywords: group, disease, Balint, relationship, psychosomatic

If it's true that it's possible, in a group, to reflect on an experience as it is happening, we could also affirm that in a group the illness and the patient take shape, they are heard, revealed and known because they are present and physically participating.
A group can be considered a smaller version of the society in which one lives and works since it reflects all the various dynamics that occur in everyday life.
It is possible, therefore, to use the group to form interpersonal relationships allowing us to bring together a group in a defined place and space; all the energy, dynamics, experiences, affective/emotional reactions and all that occurs or has occurred in the doctor-patient relationship.
<<A formation group, and we could say, the illness in a formation group could be seen as elements of the same system, that of the operator-patient relationship. This is, as are all human relationships, a complex bond, profound and dynamic, made up of constant fluctuations of the unconscious level, irrational, psychic and conscious levels, rational and somatic. The so called psychosomatic dimension takes shape in the group through reflection on the relational experience as felt in its totality>> (Sapir, 1980; Agresta & Agresta 2006).
In this case, the balint group is the most used method of psychosomatic formation for doctors and, on a wider scale, the most used method for training in interpersonal relationships for all "psy" operators and non (nurses, social workers and teachers).
The work of the GB studies the operator's obvious counter-transference (Balint, 1957; Balint & Balint, 1961); the way in which he uses his personality, culture, scientific convictions, his standards of automatic reactions, etc. The GB is not a therapy group, much less a supervision group. It is, rather, a group that helps the operator learn not to act without listening and without reflecting on the relationship

and the emotions he feels the moment the patient asks for help. The operator is also taught to focus on the patient's request for help and the problems inherent in that request using the "flash" technique (Agresta, 2006)

One of M. balint's better insights was to consider the "medical doctor" as one of the most used drugs. The doctor often uses himself in the diagnosis/relationship with the patient but oftentimes he is unaware of the correct dosage and counter-indications.

Experience and common sense are not enough in this case. If we take note of all the instructions given with any medicine, we realize how difficult it can be to take the correct dose at the right time and right way. Medicines have secondary effects. The "medical doctor" has iatrogenic effects which are his response to the patient's request: that is to say, the nature of the relationship and relational competence (Minervino, 2004). Let us see why: according to many authors, (Di Donato, 2000; Luban-Plozza, 2001; Agresta, 2003a; Minervino, 1994; Trenkel, 1974; Agresta, 2005) there are people that hide behind the illness even before the illness is structured. In their suffering, these people live in an existential/social dimension and seek answers and solutions of a physical and organic nature in the figure of the "redeeming and omnipotent" doctor or professional. While the organic patient is reassured to hear the doctor conclude that he is well, the psychosomatic patient is hardly ever reassured. Clearly, this type of patient suffers deep and painful discomfort just as much as the "organic patient". However, these individuals communicate through a sick and suffering body and are often "wounded in the spirit". Referring to the concept of psychosomatic sickness, Sapir (1980) would say that patient and operator are "hyphenated sick" in fact, both have a tendency of considering the human being as two separate entities, mind and body. The patient prefers listening to his physical ailments in order to be heard; on the other hand, the operator, generally, is used to standardizing the concept of sickness, giving it a strictly rational meaning and therefore providing causes and remedies that concern the concrete, the material and energy (infinite clinical exams). The body is sick and the body given up in the relationship is a sick one but it has been proven that man is a "psycho-sensorial" being meaning that body and mind are in constant "dialogue" and in constant dynamic exchange. Recent studies in psychosomatic circuits (Biondi, 2002; Agresta, 2003) have shown that, in a group, as well as in the therapist/client dual relationship, structural and functional changes of the nervous system through the therapeutic use of the word and the relationship (verbal psychotherapy) are measurable and verifiable. The word, the relationship are therapeutic instruments. At this point, we can ask ourselves how much "psychosomatic" is there in an illness? How much "psychosomatic" is there in a group? These questions, theoretically, have clear answers in the case of psychosomatic patients but in a relational and clinical dimension it is more difficult: in fact, the operator must find a channel of communication that is common and functional in a suitable and balanced place. The balint group has this function. In the balint group, therefore, these individuals and their bodies communicate through the case relator and so guide the group, the relator and the leader to reveal, not the superficial message, but the profound message. The

group takes care of the patient's sick body. The space of the group, therefore, becomes that place and that moment of listening about the illness and the discomfort.
As the relator (R) speaks to the group (G) about a clinical case, that is about the relationship he has had with that patient (P) (illic et tunc), R relives such event (hic et nunc). It is possible that this relationship lasted a few years or perhaps for only one conversation but it was nonetheless an experience filled with emotion, anxiety, fear, joy. R will give an account of this event in only a few minutes. Now R will convey these emotions through that which the group (G) and the leader observe in r's obvious counter transference, the way he communicates and uses his own body, for example, as he describes the meeting with his patient. At this point R begins to identify himself with P and carries out, that is relives, that exact event here and now in the group; now the G, listening to the account, personifies with R, hic et nunc. In this way, however, G will become P because it will evaluate the quality of the relationship between R and P. In fact, what happened between R and P illic et tunc is what is now happening hic et nunc between R and P in the group. The relationship between R and P depends on how the relationship between R and A was experienced and felt (Agresta & Ciritella 2004). It is, therefore, important to understand what kind of rapport is established in the GB. The GB, in this aspect, is full of perils and easy resolutions and its limitations are easily visible when the setting's management is not balanced and well structured. In this case, the leader has huge responsibilities: he must not transform the GB into a therapy group, much less a supervision group.
We emphasize that the relator carries out three distinct, yet at the same time inclusive and related relationships in the GB: the relationship with the patient, the relationship with the leader and the relationship with the group. The group, intended as space and place, in this complex systemic/dynamic sense allows full understanding of the patient's request to the relator/operator through a united and combined effort of the members, of the relator himself assisted by the leader, regarding the above mentioned relationship of the dynamics occuring here and now.
The patient's spectre and illness become the main actors. Through a counter transferal analysis shown by the relator <<*at this point it deals with a situation of formation based on a guided professional experience which carries a degree of involvement equal to that which each participant is willing to undertake and, through an explanation of the case, has the relationship between patient and operator as its objective*>> (Ancona, 2004). Each of the relationship typologies present together in the GB involves a change in the relator/operator persona regarding his relationship with the patient. Here is an example. I refer to the case in a Balint group for socio-sanitary operators in which I partecipated (Rotondo, 2005). *Clinical case of a man with ulcerative colitis*. The presenter is a doctor and a psychotherapist, 48 yrs. old. "*The GB (balint group) discusses the case of a patient we shall call 'Remo'. I contacted him after he left a message saying that he was 'doctor x's boy' and he wanted an appointment. He left his name, surname and telephone number as requested. I would like to say beforehand that the colleague who sent me this patient, with whom I often collaborate on other cases, asked my availability for this 'serious*

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case' and explained certain details of the boy's medical and psychological situation to me, namely that he was being cared for at the local hospital clinic. My colleague had had a previous conversation with the boy. As per my routine, I called him back and we set a date for an appointment with little talk or explanations. He arrives at the appointment with his mother. Before letting them in, I ask if both wanted to come in since it was the boy alone who contacted me. The mother, who was very condescending, replies that she can leave and will wait for him, not in the waiting room, but downstairs. The boy had, however, expressed his desire to enter alone. Before leaving, his mother asks him if he remembers where he parked the car. Remo is a bit offended and answers 'of course I remember!'. After having described the patient physically and quickly - compared to other cases, I have to say that I take more time and am complete in my presentation – I realize that I can't remember anything about him. I only know that Remo is confused, that he would like to continue his university studies (he has a diploma), that he wants to work and continue his hobby which is modern dancing. What else? I can't remember anything else! The group asks me many questions about him but I answer with brief notations. I seem stuck and occasionally remember some elements of his case. everything else is darkness. I do not remember the sickness, his being sent to me….nothing. I try to recall what my colleague psychotherapist told me. Again, I find difficulty relating to the group. The group, consequently, is bewildered by my 'impasse' (it has never happened! I have always been so precise) the slowly….some light! I remember almost suddenly. A flash! Remo came to me because he has ulcerative colitis and a relative of his – with the same sickness, recommended therapy for its psychological aspects – and resolved his own problem with psychotherapy. Remo, on the other hand, has received 'only' lots of advice from different doctors, often in disagreement with each other! I thought 'how confusing!' however, during our conversation, I get the impression that Remo is more evolved than others in his family, although i hardly know him. He calls for other appointments before deciding to begin therapy. He said 'I want to be cured'. I do not know if it is appropriate to speak of case solutions or not but I believe I literally 'split' the person, his emotional part and his serious psychosomatic illness. I repeated the dynamics in the balint group. Does separating also mean 'defending myself'? After all, I am a doctor and a psychotherapist. The group pointed out the problem: I have to reunite the two parts. First, as a doctor and psychotherapist, I encourage Remo to speak what is on his mind, about the maternal figure, his father, but also the psychological meaning of his illness, then analysing dreams (Remo told me that he cannot remember many dreams) that act as a bond between mind and body, especially with these illnesses. Although, in reality, I am both a doctor in a public institution, and a psychotherapist in a private practice, put face-to-face with an illness where both 'psyche' and 'body' are involved and where my role is to unite mind and body, I realized, in this particular case, I had separated and removed it. The balint group helped me 'remember' the 'story' and I was happy to have found that unity in Remo's person".

In the case referred to, the operator was able to regain mind-body unity through the work with a group. The illness in its holistic/complex vision is reunited because the patient is reunited with his psychosomatic realty/dimension. Particularly, the limited change of the doctor consists in a broadening of his horizon, in an analysis and global diagnosis (*Gesamtdiagnose*) and in greater openness and sensitivity for non-verbal messages in a doctor-patient relationship (Agresta, 2005).
The group experiences this dimension through that which is spoken verbally and non-verbally, in "the group's space", in this dimension where rationality and irrationality meet. Even the leader, who must immerse/fuse himself with the group as much as possible, does not interpret in a classical sense though having an analytical formation, but observes and clarifies the doctor's attitude towards his patient. It's as if he were the "director" of an orchestra, as Foulkes would say! He acts as a unifier. He guides the group in the interpretation and in giving the musical work its coloring, but all in all, he only coordinates the orchestra and each of its members without breaking up or unbalancing the harmony and flow of the piece in its entirety.
In modifying the operator's personality and, therefore, in better understanding the illness, the group is the most important relationship in the GB. The leader is less essential.<< *At the same time, however, it is necessary that the leader gradually allow the group the freedom it needs to express itself in a constructive/aggressive way. It is important to have both elements together as pure aggressiveness and mild constructiveness are useless on their own*>>. (Di Donato, 2000).
As Balint and his students have always emphasized, of fundamental importance is the operator's counter-transferral response, and not only his technical capacity or scientific knowledge regarding his specialization or therapy. As we know, the parameters of formation reflect the two fundamental rules of medicine and psychoanalysis: treatment and knowledge (Agresta, 2003a). With the development of Freud's discoveries, psychoanalysis has gone beyond the aspect of "treatment" and has probed the field of knowledge of human psyche, of the workings of the individual (Gilliéron, 1994): pyschoanalysis has opened up the possibility of exploring the unconscious, of studying defense mechanisms, interpreting dreams and so on. As a doctor and psychoanalyst, Balint was moved by both souls but, since the beginning of his work and in his analytical practice as a "former". He traced an intermediate area, such concept dear to D. Winnicott – is the psychological formation of the doctor and health worker whose formation is channelled towards a new road, that of the formation of interpersonal relationships. The other aim is to create a therapeutic alliance which goes beyond a more sophisticated and clever technicality. In clinical areas, both psychotherapy and medical and/or psychological consultations, the balint group is a valid instrument of formation. It teaches the operator to reflect and extricate himself from the illness, in the labyrinth of verbal and non-verbal messages, in a more definite and finalized way. In fact Balint, besides "active therapy" technique, introduced two further elements of direction/intervention: the flash technique, where the aim is that of letting the patient know "it is understood" (I know

you know that I know) and the focal therapy, where only symptoms, dreams and conflicts relating to the therapeutic request are interpreted (Agresta e Ciritella, 2004).
This way, prepared for relationships by his formation in a balint group, the operator acquires another therapeutic weapon (Trenkel, 1974, 1995). He will know how to weigh his words in a wise and less imputent way with other operators. He will, in fact, try to know himself in order to better know the other and avoid creating confusion in speech that, within the relationship/communication, does not facilitate understanding of the request and the therapeutic reception/alliance with the patient and his illness.
Within the group, the operator has the opportunity of sharing what he feels and what he has experienced with that patient with his own body, the same included in the "body-group". The group thus becomes the best place and space to both understand the illness and avoid it (burn-out).
A comparison, as K. Rohr (2003) points out, might be that of persons hurt by burn-out to that of victims of traffic: *<<both literally let themselves get run over because they paid little attention to what is both necessary and essential to them: the physical and psychic integrity of their interior and exterior humanity. That does not mean that we would like to eliminate traffic. It is oftentimes a necessity and an aid to us (technological progress) but we want to learn to pay attention to ourselves in this traffic, to preserve our humanity within the freedom of interior and exterior movement>>*.
Man's illness often finds expression through "parts of the body". It is relived through the living experience of the GB and in the relation of the here and now that it proposes, objectively through the "members of the group" (the body-group), the "concrete phantom" of that patient and of his body in the there and then.

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