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Group Psychoanalysis: Reporting on 50 Years of Work

Balint Group: tradition and transformations of the working group

Talking with Mario Perini, founding member of 'Il NODO Group' on the topic of "groups" within organizations

Edited by ***Piera Ferrini***

1) You have a significant professional history in the field of institutional group analysis, can you tell us how and why this interest was born and how it has developed over time?

I currently work as a psychoanalyst, both following patients in psychotherapy and using the theories and tools of psychoanalysis to offer counseling to institutional groups and management figures in social-health contexts but also in other organizations such as schools, public administrations and companies. Before becoming a psychoanalyst, I worked for some fifteen years as a psychiatrist in mental health services, witnessing among other things the closure of the asylum - the Collegno Psychiatric Hospital where I gained my first experiences - and the birth of the new territorial psychiatry - the first outpatient clinics, the Psychiatric Ward, the therapeutic communities, where I carried out most of my psychiatric practice, profoundly influenced by the Basaglian lesson, the focus on institutional processes and the valorisation of

group work, i.e. of the interprofessional team. In 1985 I had completed my psychoanalytic training in the Italian Psychoanalytic Society but at that time it was not possible for me to transfer this new competence to the services, so I resigned and went freelance as a psychotherapist; However, I never recovered from the 'institutional illness', from my passion for group and organizational dynamics, and very early on I flanked my office work with patients with a series of training activities, supervision of operational groups and clinical-institutional consultancies, activities that I still carry out today and in which I trained mainly at the Tavistock Institute in London.

2) You are one of the founding members of the association il Nodo Group which became a social enterprise some time ago, can you describe your working model with institutions?

Our working philosophy is based on the assumption - largely tributary to Bion's studies, Tavistock's research and also systemic theory - that institutions are not only rational structures oriented towards the performance of a task or the achievement of an objective, but are also 'organisms' conceived, constructed, inhabited and governed by human beings and as such influenced by the emotional, non-rational and often unconscious processes that characterize the behavior of people, individuals as well as groups.
When an organization - a hospital, a company, a school, a professional group, a non-profit association - is confronted with difficulties, which can range from a drop in turnover to widespread conflict among its members and which it is unable to resolve with the usual tools, then it can turn to consultancy. Our consultancy model, while not excluding the usefulness of technical, procedural or financial interventions, proposes an approach more oriented towards organisational diagnosis and change; This implies the exploration of emotional processes and group and organizational dynamics operating in the institutional context, in order to develop in people - in leaders as well as employees - an increased awareness and responsibility with respect to the problem identified and its roots, a greater ability to maintain processes and institutional structures, more effective support for management roles and work groups, and above all the creation of an organizational culture that values emotional-relational skills, the balance between change, efficiency and sustainability, and learning based on experience, our own as well as that of others.
The tools we can use for these consultancies are varied - supervisions, experiential seminars such as Group Relations Conferences, role counseling, executive coaching, institutional observations, Balint groups, Social Dreaming matrices - but they are all included in a theoretical-practical paradigm

developed by the Tavistock, which is called the 'systemic-psychodynamic approach'.

3) **I would like to share with you some reflections on the role that health workers currently play in our society. In the past, we health service workers felt that we represented a social mandate in carrying out patient care and we felt part of an institution that had this mandate; today, on the other hand, the health institution has reduced this role in favor of greater technicality and greater centrality of economic aspects. Do you agree with this interpretation and in your experience what does this development mean for health workers?**

I do not simply wish to add my voice to the chorus of lamentations - which are, moreover, fully justified but very ineffective - that are sweeping through the world of the health professions, and not only since today or with the outbreak of the pandemic, but for some time now. The role of 'caregivers' in our society has sometimes been idealized (from the resounding successes of medical science to the applause from balconies during the first wave of Covid), and at other times denigrated (from the persistent disqualification of family doctors to the assaults on emergency room personnel), but the health institution, with rare exceptions, has never known how to valorise it in a realistic and constructive manner, especially when the objectives it pursued were more concerned with saving money and avoiding litigation than with the health of patients and the well-being of personnel.
However, this role now seems to me to be exposed to a decisive and radical transformation, potentially positive but not without tensions and risks to health and freedom, as a result of a profound change taking place in the culture of health; This change has, on the one hand, enhanced the patient's autonomy with respect to decisions on treatment - which until recently had been trapped in the paternalistic idea of 'compliance' to the doctor's prescriptions - and, on the other hand, is introducing into the caregiver-patient relationship a 'third element' of boundless power, digital health with all the weight of algorithms and artificial intelligence. I am not a health sociologist, but I believe that the future of the care relationship, provided that the aforementioned risks are adequately taken into account, will see the role of the health professional less designed in the terms of the expert who knows, who prescribes, and who governs the processes, but rather as a professional who, although competent, is well aware of the value of the patient's perceptions and opinions about his or her own health, and who therefore proposes to him or her a relationship of collaboration and working alliance

between adults. Similarly, with respect to digital health, the caregiver will have to act as an interpreter and mediator in order to help the patient to use the new technologies correctly and profitably, without giving up the 'human side' of the care work.

4) Could you illustrate new models of group training closer to current needs?

Group training in health care is now an unavoidable requirement, given that it is no longer imaginable for a care task to be performed alone by a professional, no matter what and to what extent he or she is an expert. Today, every kind of care involves an interdisciplinary team, even when a practitioner is working alone, because no single professional possesses all the information, skills, tools, authority and opportunities that are needed to carry out a care intervention. If, therefore, the carer is now a multi-professional subject, then training cannot but begin with training to work in a group, starting with learning what makes a set of people a 'group', what emotional dynamics run through it, which of these are useful to make it function as a 'working group' and which are dysfunctional. The academic training of health workers, doctors in the lead, almost never includes such training, leaving them exposed unarmed in the workplace to a never-ending series of tensions and conflicts around the typical institutional dilemmas between identity and belonging, dependence and autonomy, collaboration and competition.
Therefore, the new training models should include many moments of group experiences, more or less structured and in any case guided by counsellors expert in the dynamics of work groups (which are often different from those of therapeutic groups): among the available models I will only mention those I know best, the experiential seminars on group relations, Balint groups, peer reflection/intervision groups, Social Dreaming matrices, psychodrama groups. They can also be used with groups of trained professionals, in this case as tools to offer psychological support in difficult situations or traumatic experiences.

5) You are an experienced Balint group leader, what do you consider to be the greatest difficulties in leading a group of health professionals?

One of the difficulties, which I have already mentioned, is the lack of habit of working in groups, which concerns almost all health professionals, with the sole exception of mental health service teams and, to some extent, operating theater and emergency teams. Another difficulty arises from what Bion calls 'basic assumptions', whereby emotional-relational dynamics tend to emerge

in groups based on the need to depend on an ideal leader who will know how to solve every problem (the basic assumption of Dependency) or on the need to designate an external danger (or an internal scapegoat) with which one will have to fight or from which one will have to flee (the basic assumption of Fight/Flight). Conducting groups can thus become difficult because the members may expect from the leader a decisive answer to the dilemmas presented, a strategy to protect them from the anxieties of the job, a definitive judgment on who is right and who is wrong in a confrontation of opinions, absolving, affectively sided attitudes or other similar expectations. Finally, I would say that a specific difficulty for the conductor consists in distancing oneself from the implicit mandate of the institution, which may be concerned above all with ensuring the quality of services - which is certainly a must - but may turn out to be indifferent to the well-being of the operators. This model, which usually corresponds to the classic 'clinical supervision', may influence not only the organization of these training groups, orienting them exclusively to the control of the quality of care, no matter at what personal cost, but may even condition the attitude of the members who, probably intimidated by the idea of exposing their emotions in a group, focus on the technical aspects and the choice of the best therapeutic strategies. After all, who ever explained to them that emotions - and the words and deeds that translate them - can generate positive as well as negative effects on brain functions and are therefore relevant to the care relationship?

6) **The healthcare institution is in a state of serious distress, I would say we are in the presence of an 'institutional collapse', the institution no longer has the capacity to adapt in the presence of destabilizing variables (see COVID pandemic), how could your working model intervene on this trend?**

As has been reported in many quarters, the healthcare institution is close to collapse, and for many different reasons, political-economic, cultural and organizational. I do not have the expertise to deal with such a complex issue, but I have the impression that one of the new fronts where more investment and attention is needed is 'community medicine' with the development of home care, proximity facilities and tele-assistance devices. Our working model, centered on teamwork and on the caregiver-patient alliance, could develop not only consultative moments to accompany strategic and operational decisions weighed down by the anxieties of change and uncertainty, but also and above all provide stable opportunities for support, both psychological and organizational, for the new interprofessional teams involving doctors, nurses, psychologists, social workers and other operators in the difficult task of tackling two orders of problems at the same time

- learning to work as a team and to help each other 'among equals' in the diversity of roles, techniques, knowledge and languages
- taking care of an increasingly chronic and vulnerable population in 'foreign' contexts such as homes, RSAs and other territorial facilities

7) Balint groups are not very widespread in Italy, do you think that new ways of group approach should be sought? What could they be?

In Italy, Balint Groups were popular until the 1970s-80s, then they gradually disappeared, just as Balint's book, “The Doctor, his Patient and the Illness” disappeared from bookshops and was no longer reprinted, at least until the Balint Centre of my Association, Il Nodo group, edited an updated re-edition of the volume for the Fioriti publisher in 2014, as well as relaunching Balint groups as support initiatives for caregivers. This disappearance can be explained at least in part by the move away of medicine and health cultures in general from the psychological dimension of the care relationship, in favor of more technical and procedural approaches.
The scarce diffusion of the Balint group method, even today and in spite of the growing attention to the humanisation of care and the initiatives of institutions such as the Italian Society of Psychosomatic Medicine (SIMP), the Italian Medical Association Balint Groups (AMIGB), the Roman Balint Analytical School (SRBA), and the Balint Centre of the Nodo group itself, perhaps has deeper roots, located in the very identity structure of the figure of the physician and in part also of the other health professions. The doctor treats with what he knows and with what he knows how to do, while it is very difficult for him to think of treating with what he feels, with what he imagines or with what he says, in other words with his own personality, what Balint had highlighted with the expression ‘the doctor as a drug’. We have observed how doctors are uncomfortable when they come into contact with their own emotions and even more so when they are invited to express them and share them in a group, a situation in which they are afraid of showing an image of themselves as incapable, weak and powerless, or sick and dysfunctional, something to be ashamed of or to feel guilty about, and therefore to be kept hidden. If this then occurs in an inter-professional group, in front of other figures and disciplines, it can become even more embarrassing.
The experience of the Balint groups induces the participants to explore themselves quite in depth and this is perceived as too high a risk or an intolerable experience for many people; some general practitioner colleagues left a Balint group, which they themselves had requested, stating that they perceived it as a very useful and stimulating instrument, but that they then

had nightmares during the night and therefore did not feel like continuing. An effective drug but with too many side effects.
These findings - together with the fact that “the IL NODO's Balint groups” were increasingly being attended predominantly by psychologists, whose interest seemed to be mainly in learning how to lead them - led us to review our training and consulting practices and to develop forms of group support that better respected the carers' emotional vulnerabilities. Thus we turned to more sustainable group models, centered on peer sharing of experiences of working in difficult situations, with a less 'expert' and less interpretive conduct, more in the sign of facilitating exchanges of reflections in the group and maintaining an open and non-judgmental climate. These groups, which we call 'inter-vision' groups, remain within the theoretical and operational paradigms of a psychodynamic and systemic type that characterize the 'Tavistock method' and the 'Balint method', of which they can represent a kind of preparatory experience.

Thank you very much for this dialogue; your collaboration has been invaluable in the deepening of these topics that are already important today and will become increasingly relevant in the near future.

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