Reading Balint group work through Lacan’s theory of the four discourses

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Abstract
In Balint groups, (para)medical professionals explore difficult interactions with patients by means of case presentations and discussions. As the process of Balint group work is not well understood, this article investigates Balint group meetings by making use of Lacan’s theory of the four discourses. Five Balint group case presentations and their subsequent group discussion were studied, resulting in the observation of five crucial aspects of Balint group work. First, Balint group participants brought puzzlement to the group, which is indicative of the structural impossibility Lacan situates at the basis of all discourse (1). As for the group discussion, we emphasize ‘hysterization’ as a crucial process in Balint group work (2), the supporting role of the discourse of the analyst (3) and the centrality of discourse interactions (4). Finally, the potential transformation of the initial puzzlement is discussed (5). We conclude by putting forth the uniqueness of Balint group work as well as the potential usefulness of our analysis as a framework for Balint group leaders and professionals in charge of continuing medical education.

Keywords
Balint group, discourse, Lacan, psychoanalysis, qualitative research

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Introduction

Over the last decades, the importance of the doctor–patient relationship has been increasingly acknowledged, especially in general practice (Bower et al., 2001; May et al., 2004). As this relationship is the motor of everyday practice, it needs careful attention. However, everyday practice frequently leaves little time for general practitioners (GPs) to explore the doctor–patient relationship and the difficulties related to it. Nevertheless, dealing with these types of difficulties is of the utmost importance as they may affect both patients’ health (e.g. consulting the doctor when needed, complying with a prescribed treatment) and physicians’ health (e.g. burnout as an important problem among GPs; Bria et al., 2012; Milner et al., 2013). Therefore, some authors (e.g. Arnaud and Vanheule, 2007) recommend creating a space in the professional context where people can express elements of their own subjectivity. By offering participants a platform to explore subjective issues related to their professional work with patients, Balint groups (BGs) can provide such a space (Balint, 1964).

BGs were first set up in the Tavistock Clinic in London during the 1950s by Michael Balint (1896–1970). The first BG consisted of GPs who had answered a call in the Lancet (1950), proposing a ‘discussion seminar on psychological problems related to medical practice’ (Balint, 1969: 202). This initiative is to be situated in a period when general practice was under great pressure as the medical world was confronted with many post-war health problems. Hereafter, BGs started spreading worldwide, albeit on a limited scale (Salinsky, 2002). Participants usually include GPs, although sometimes groups also welcome other professionals in the (para)medical field. Typically, BGs comprise 6–12 members and one or two leaders (also called ‘animators’). Meetings usually take place on a weekly to monthly basis over a time span of several years. During these meetings, participants are invited to present cases in which they are confronted with a specific difficulty in the doctor–patient relationship. They are asked to report freely about their experience, without the use of notes or files (Balint, 1964). Usually, one or two cases are discussed each session, which lasts between 1 and 2.5 hours. After each case presentation, a group discussion is held focusing on thoughts, emotions and subjective reactions that the case might have evoked in each participant. This way of working (related to the psychoanalytic notion of ‘free association’) creates the possibility of being surprised by alternative perspectives or by one’s own utterances that were not yet conscious.

Descriptions of BG principles and occasionally of group sessions can be found. However, research of the ways BGs function and the possible processes at work here is scarce (Van Roy et al., 2015). Since process research mainly identifies separate factors, more comprehensive and explicitly theoretically driven studies are needed. This study qualitatively examines the process of BG work by making use of Jacques Lacan’s theory of the four discourses. We decided to use this framework as it emphasizes both the social bond and the importance of language. These are indeed two aspects that are crucial in BG work: group members focus on difficulties in the social bond with their patients by means of verbal exchanges in the group. Before proceeding any further with the methodology used in this study, we first present Lacan’s theory of the four discourses as specific elements thereof are at the basis of our data-analysis.
Lacan’s theory of the four discourses

Building on Freud’s foundations of psychoanalysis, the French psychiatrist and psychoanalyst Jacques Lacan (1901–1981) developed several theoretical schemes and formalizations in his seminars, which were held from the 1950s up to the 1970s. These schemes, among others, include his theory of the four discourses, introduced during Seminar XVII ‘L’envers de la psychanalyse’ (Lacan, 1991) and further developed in the next Seminar XVIII ‘D’un discours qui ne serait pas du semblant’ (Lacan, 2007a), the text ‘Radiophonie’ (1970) and Seminar XX ‘Encore’ (Lacan, 1975). For his theory of the four discourses, Lacan was inspired by the seminal work of the founding fathers of structural linguistics such as Ferdinand de Saussure (1857–1923) and Roman Jakobson (1896–1982). In line with most of his other schemes and formalizations, Lacan makes use of algebraic symbols to explain the functioning of the four discourses he discerns. This type of far-reaching abstraction is typical for Lacan’s work: using formal structures, he attempts to avoid fixed meanings and one-sided interpretations (Vanheule, 2011). This, however, also implies that trying to understand these mathematically presented structures is a rather arduous and difficult exercise.

Lacan’s theory of the discourses is a formal system that outlines different types of fundamental relationships or social bonds. According to Lacan (1975), social bonds are rooted in language. A child’s acquisition of language or, as Lacan puts it, the introduction to the Symbolic, coincides with the loss of a mental state of totality. Henceforth, the child creates representations of reality, as a result of which absence and lack too obtain a mental status. For example, a dissatisfied child can imagine states of gratification and addresses the other through language, although neither the representations nor the other’s responses will ever fully solve the dissatisfaction. In Lacan’s view, this experience of subjective lack is crucial to human beings: lack engenders subjectivity and marks all later experiences in life. Nonetheless, different modes of dealing with subjective lack can be distinguished. In his theory of the four discourses, Lacan outlines four ways for the ‘divided subject’ to deal with the human condition of lack, which result in four different kinds of social bonds.

Principally, Lacan’s discourse formulae consist of four terms and four positions. The four terms can rotate – in a fixed order – over all four positions, resulting in four different discourses. The four positions (Figure 1) are defined as agent, other, product and truth. In each of the discourses, the agent (in the upper left-hand corner) addresses the other (in the upper right-hand position) in a relationship that corresponds to the manifest

![Figure 1. The four positions and two disjunctions in Lacan’s discourse theory.](image-url)
expression of a speech act. The agent is not to be seen exclusively as a concrete person, but can also be apprehended, for instance, as an ideology or tradition (Neill, 2013). However, this agent is only the apparent agent of the discourse: the operation at the upper level is driven by what Lacan calls the truth (in the lower left-hand corner). This truth is unknown to the agent and, moreover, cannot be completely known or verbalized as ‘it is only accessible through a half-saying [mi-dire]’ and ‘cannot be said completely, for the reason that beyond this half there is nothing to say’ (Lacan, 2007b: 51). Therefore, this process results (in the lower right-hand position) in a product, which always implies the creation of an irreducible rest or loss, as that which escapes the discourse.

Besides the four positions, the formal structure of each discourse contains two disjunctions. At the upper level of the discourse, there is a disjunction of impossibility (represented by a one-way horizontal arrow ‘→’), which is closely linked to the disjunction of impotence at the lower level (represented by a double bar ‘//’). The upper disjunction, that of impossibility, indicates that all human relations are marked by an impossibility, which leads to discontent. Harmonious communication and connections do not exist: the agent is driven by a truth that cannot completely be verbalized, and in addition to this, the message an agent conveys is never perceived by the other as it was intended. This disjunction of impossibility is tightly connected to another disjunction, that of impotence (at the lower level of the formula), which concerns the ‘impotent’ link between truth and product. This impotence concerns the aforementioned fundamental subjective lack, which, structurally, cannot be undone. In the hope of overcoming this lack, the subject addresses the other, but this attempt always fails somehow.

Across the four discourses, the positions and the disjunctions remain the same. However, the positions are each time occupied by different terms, which rotate over the discourses. The four terms ($S_1$, $S_2$, $\$\$ and $a$) are key concepts in Lacan’s work. Two of the terms, $S_1$ and $S_2$, are ‘signifiers’. Put briefly, signifiers are the material elements of which language is constituted. Typically, they are words or fragments of words by means of which we build sentences and narratives. $S_1$, the master signifier, is any signifier that dominates a discourse and provides sense; it is a term, phrase or concept that dominates a discourse without it being questioned. For example, in contemporary medicine, ‘evidence’ is a master signifier, just as in religion, ‘God’ is a master signifier. $S_2$ represents the body of signifiers by means of which knowledge or messages are communicated. Characteristically, knowledge and messages are constructed around master signifiers, which is why across the four discourses, $S_1$ always precedes $S_2$. The other two terms are both an effect of the signifier. The third term is $\$, the divided subject, barred due to the aforementioned subjective lack that resulted from the introduction of language. Through language we connote who we are and what we live through, but it remains impossible ‘to say it all’. The fourth term ($a$) stands for the ‘object $a$’, referring to what is left behind by the introduction of the Symbolic (Lacan, 1973, 2004). As we use language to express ourselves, there is always an unsaid remainder. The divided subject is driven by this remainder, but it can never be attained, which is why across the four discourses, ($a$) always precedes $\$$. 

The rotation of the four terms in a fixed sequence over the four positions results in four discourses. As mentioned earlier, these concern four modes of relating to the other, or four types of social bonds, each allowing for certain effects, but at the same time hindering others (Fink, 1995). Therefore, discourses may have an impact that is experienced
as agreeable, but all contain their disjunctions as well, which make them disagreeable at the same time. In what follows, we briefly present the four discourses. Starting from the discourse of the master, the other three discourses ensue by rotating each term one counterclockwise quarter turn. By way of clarification, we provide an example from the medical context for each of the discourses.

**Discourse of the master**

In the discourse of the master (Figure 2), the master signifier is in the position of agent. This discourse represents power and mastery: the ‘master’ must be obeyed simply because he or she says so (Fink, 1995). As referred to before, this ‘master’ does not necessarily refer to a personified authority, it can also be understood as an ideology, ‘a socially identified ruler or the psychic mastery of each and every individual’ (Nobus, 2000: 94). In the discourse of the master, a straightforward idea is accepted as self-evident. At the manifest level, the master appears as a solid rock, undivided. Qua straightforward idea $S_1$ generates a sequence of signifiers and ideas, which constitute knowledge ($S_2$) and which are organized around what we accept as self-evident. However, the hidden truth or driving force behind this discourse is that the master signifier is not self-evident and only based on subjective preference and belief ($\$$. Therefore, in the formula, the divided subject makes up the truth of $S_1$. Moreover, the discourse of the master is marked by an inherent impossibility: not everything can be contained in signifiers. This results in an ever-increasing production of surrogates of the object $a$, the lost object, that are not capable of reducing the subjective lack. In other words: ‘no matter how hard a master ($S_1$) tries to govern and control knowledge ($S_2$), the latter will always partially escape’ (Nobus, 2000: 94).

![Figure 2. Lacan's representation of the discourse of the master.](image)

In the context of a medical consultation, this discourse could be exemplified by a physician expressing a diagnostic judgement (e.g. ‘you have measles’) or medical advice (‘you should stop smoking’), the diagnosis or advice being the $S_1$. In a way, the discourse of the master reduces the patient to ‘a medical object’ (i.e. a diagnostic label or someone who should subscribe to well-intended advice) while at the same time neglecting the truth that the doctor himself or herself is divided as well. Nonetheless, a doctor in his or her professional role is – to a certain degree – expected to use the discourse of the master: he or she is supposed to make diagnoses, to intervene and to take position at crucial moments, and not to let his or her subjectivity prevail. It is only a rigid use of this discourse that might be problematic.

**Discourse of the university**

In the discourse of the university (see Figure 3), constituted knowledge is in the commanding position, approaching the other as an object to whom this knowledge can be
applied (Verhaeghe, 2004). The hidden truth is that knowledge rests on ideas that are accepted as a self-evident doxa: a master signifier underpins all knowledge. Principally, the discourse of the university is tantamount to rationalization and the transmission of already established knowledge. However, if the other is treated as an exemplar of the agent’s knowledge, divided subjectivity will be excluded and therefore produced: knowledge cannot exactly denote the other. Hence, between the $ that is produced and the $1 that is used as a reference on the basis of which knowledge essentially builds, no correspondence at all can be found.

In the context of a medical consultation, this discourse is at work, for instance, when a doctor provides statistics and scientific information ($1) indicating how harmful smoking is to one’s health ($2). This knowledge is communicated to the patient who is essentially reduced to an object or, more precisely, just another example of a smoker ($), to which specific knowledge is applicable. This type of approach, however, rules out the patient as a (divided) subject with respect to his or her specific relationship to smoking ($). Similar to our comment about the discourse of the master, the discourse of the university constitutes a necessary part of a doctor’s job (e.g. in the form of sharing and providing information to patients). Similarly, it becomes potentially problematic if the doctor’s discourse is reduced to that of the university.

**Discourse of the analyst**

A subsequent counterclockwise turn produces the discourse of the analyst (see Figure 4) as the inverse of the discourse of the master (i.e. all terms in one discourse are situated at the opposite place in the other). What is at the hidden level in the discourse of the master is manifest in the discourse of the analyst and vice versa. This discourse refers to the position a psychoanalyst typically occupies: she or he asks for free association and invites the other to grasp something of that what has not been said, that is, object $a$. Along this way, the subjective division ($) of the other is brought forward. In this discourse, knowledge is situated at the place of the truth: the analyst is informed by knowledge about psychoanalysis and psychopathology, and precisely because of this, she or he hangs on to occupying the position of the ($a$). Knowledge ($2$) motivates the process but is neither transmitted nor made

![Figure 3](https://example.com/figure3.png)

**Figure 3.** Lacan’s representation of the discourse of the university.

![Figure 4](https://example.com/figure4.png)

**Figure 4.** Lacan’s representation of the discourse of the analyst.
explicit; in other words, it is kept under the bar. In this discourse, the subject that is addressed produces new master signifiers, that is, crucial ideas and insights on who she or he is and on what she or he is marked by.

Although this type of interaction is probably rare in the context of a (classical) medical consultation, some GPs occasionally engage in the discourse of the analyst. For example, when the doctor attentively listens to the patient’s narrative and puts the complexities of the patient’s story central, the discourse of the analyst is at work.

**Discourse of the hysteric**

In the discourse of the hysteric (see Figure 5), the agent addresses his or her subjective division to a (presumed) master at the place of the other; the latter is supposed to know and to produce an answer. This movement generates (new) knowledge ($S_2$). Given the fact that this discourse is the only one that produces knowledge, it was also referred to as the genuine discourse of science (Lacan, 2001a, 2001b), that is, the discourse that leads to innovation. However, the knowledge that is produced will always be somehow beside the point, ‘unable to produce a particular answer about the particular driving force of the object $a$ at the place of the truth’ (Verhaeghe, 1999: 110).

![Figure 5. Lacan’s representation of the discourse of the hysteric.](image)

Discourse interactions

Above all, Lacan’s discourses outline dynamics or fields of tension. This not only regards each of the discourses separately, but also the very interactions between these discourses. Indeed, to the previously described inherent logic of each of the discourses, we can now add their interrelations as well.

From the previously provided examples, it became clear that each of the discourses can be found throughout medical practice. Nevertheless, we noted that in their professional role, doctors will predominantly engage in the discourse of the master and the discourse of the university. In both discourses, the divided subject is situated at the latent (i.e. lower) level, at the positions of hidden truth and product/loss. These two ‘universalizing’ discourses find their counterparts in the other two
discourses where ‘particularity’ is put on the foreground. As already pointed out, the discourse of the master is the reverse of the discourse of the analyst and vice versa; likewise, the discourse of the university is the reverse of the discourse of the hysteric. As noted above, none of the discourses are problematic per se, but holding fast to one discourse can be; the persistence of one discourse provokes the disjunctions to play a more prominent and therefore hampering role. Due to their impossibility and impotence, discourses always fail (Lacan, 2001a); the circle is not complete (Neill, 2013). However, these failures allow a dynamic of transition between discourses and thus between social bonds (Lacan, 2001a). Due to these disjunctions, discourses keep on being produced (i.e. endless attempts to say it all) and social bonds are maintained or pluralized.

**Methods**

**Data**

For this qualitative study, five audio-taped BG meetings were analysed in depth. These tapes were part of a larger sample of audio-taped meetings that were gathered through a 1-year-long non-participant observation of four BGs. Three of these groups were Belgian (French-speaking) and one was Dutch. The first author attended all sessions as a non-participant observer. Given the fact that one researcher in this study was not familiar with the Dutch language, the Dutch-speaking BG was not taken into account in this study. All BGs had eight to nine participants and two leaders, and held monthly meetings for approximately 2.5 hours. In these meetings, two cases (lasting approximately 1 hour each) were successively presented and discussed. Although two of the three groups included were mixed (including, for instance, GPs, physiotherapists and nurses), we deliberately selected cases that were presented by GPs, as this was the focus of our research. In the selection of the cases, we further aimed at achieving a maximum of variation (cases from the different groups, cases on a wide range of topics, cases where a ‘clear’ change was tangible vs cases where this was less clear, etc.). All cases selected for this study were deemed highly representative of the BGs we observed. This study was approved by the Ghent University Committee for Medical Ethics.

**Data analysis**

In a preliminary phase of this study, the authors, who are all very familiar with Lacanian psychoanalysis, gained the impression that Lacan’s theory of the four discourses potentially was a well-suited framework for understanding BG working mechanisms. We then decided to actually test to what extent this theory could help ‘reading’ concrete BG cases. Therefore, each author started reading the first case with Lacan’s theory of the four discourses in mind. This means that we explored the way this theory could shed light on BGs: (1) by analysing the position from which statements were made, both at an apparent and at a more hidden level (i.e. the ‘agent and ‘truth’ position); (2) by trying to delineate the ‘other’ that was addressed; (3) by examining the effect that was produced (i.e. the ‘product); and (4) by identifying the turning points in the transcripts. After this individual
analysis, the authors jointly discussed different points of view and aimed at constructing a more general comprehension of BG work. These ‘preliminary constructions’ were further considered during subsequent meetings, each time in the confrontation with a new case. Throughout further constructions, adjustments and refinements, we gradually developed a representation of BG work making use of Lacan’s theory of the four discourses. Rather than ‘applying’ such abstract theory to our data, we aimed at exploring how this theory might help in making sense of the BG meeting transcripts. After having analysed five cases, all authors agreed that saturation was reached. The team of authors has extensive experience with qualitative research (grounded theory, narrative analysis, thematic coding, discourse analysis). In analysing these data, we hung on to the guidelines formulated by Vanheule (2002), who describes Lacanian-based qualitative research as a form of applied psychoanalysis, in which extra-clinical data are systematically studied. Practically, our approach might be characterized as theory-driven thematic coding (Braun and Clarke, 2006).

Findings

For the presentation of the results, we focus on five crucial components of BG work. First, there is the participants’ initial puzzlement that they bring to the group, which we understand in terms of a confrontation with the discourse disjunctions (1). Subsequently, we discern ‘hysterization’ as the central aim of BG work (2), the discourse of the analyst as the driving force of the group process (3) and the role of discourse interactions in relation to the discourse disjunctions (4). Finally, we examine the potential transformation of the initial puzzlement (5). The above components are illustrated with examples from our data.

Puzzlement: disjunctions in the discourses

In all group meetings, the proceedings were similar. After settling down, practical information is exchanged and follow-up reports from the presenters of the previous session are solicited. Subsequently, one of the animators invites the group members ‘to present a situation’. After a brief or sometimes longer silence, one group member begins to describe a situation related to the work with a patient, without the use of notes. We observed that during BG meetings, GPs always tend to report situations that puzzled them. This so-called puzzlement has three characteristic facets: the GP was affected by a clinical situation, failed to understand the situation, and did not know what to do or how to proceed. In Case 1, for example, the puzzlement the GP brought to the group regarded a patient who had expressed dissatisfaction with the GP’s unresponsiveness towards his first grandson’s birth announcement card. The patient had been concerned that the GP had not received the card and had remarked that he understood his mother claiming: ‘the more I know people, the more I like dogs’. The GP stated that he had experienced ‘indefinable malaise’ and ‘a blank mind’ in relation to the patient’s comment, and that following this statement he had not known ‘how to escape’. In Case 2, the GP described feeling stuck in relation to a violent man whom he had accepted as his patient again. Two main difficulties were put forward, which bore witness to his failure...
to adequately address the other. First, the GP mentioned the fear and uneasiness that the patient’s physically aggressive behaviour had evoked in him. He explicitly stated that he mistrusted the potential blinding effects a situation of fear could elicit, both in himself and in the patient. Next, the GP also mentioned the ‘loyalty conflict’ that this situation created since he was also the GP of the patient’s girlfriend. In Case 3, the GP reported a telephone call by a desperate mother who did not know what to do with her 30-year-old daughter, who was a patient of this GP. In the experience of the GP, this mother expected a clear answer and advice, thus putting the GP in the position of master. However, this had embarrassed the GP in question, failing to adequately deal with the request.

In each of our cases, the GP was confronted with the experience of being put in an emotionally affecting position, where he or she did not know how to respond to the patient: the GP was blocked in the social bond. In terms of Lacan’s discourses, he or she was confronted with the disjunction of impossibility. The GP failed to make sense of the distressing event, and qua agent he or she could not adequately respond to the other who was consulting him or her. The experience of failure is central here. However, in daily practice, GPs are supposed to ‘keep the machine running’ and to remain professional, which is why usually such puzzlement is not further explored. BGs, by contrast, offer a platform for elaborating around these experiences of professional difficulty.

**Hysterization as the central aim in BG work**

In the discourse of the hysteric (Figure 5), the divided subject ($) addresses the other with the aim of obtaining a master signifier (S1) that will make sense of the puzzlement one is confronted with. Applied to the BG, this first means that, by recognizing and acknowledging his or her own puzzlement, the GP assumes the position of divided subject, thus potentially starting a process of ‘hysterization’ (Fink, 1995; Miller, 1988). This implies that the presenter does not merely blame the other, but feels divided: he or she reacted in a certain way and assumes his or her responsibility for not having acted differently; it entails the induction of a question about his or her own implication in the situation. Indeed, in the BG sessions that we studied, participants were generally willing to present cases, albeit to varying degrees. However, the extent to which their subjective division was put forth differed among participants. Some discussed work-related difficulties with a principal focus on the patient or the circumstances (e.g. Cases 3 and 5); others reflected upon the potential ways they themselves were implicated in the situation. For instance, in Case 2, the presenter immediately put forward elements that may have contributed to why he had accepted the man to become his patient: he felt both seduced and put under pressure by the patient, and he was hoping to be able to do something for the patient’s girlfriend.

Furthermore, both the master signifier that is supposed and addressed and the type of knowledge that is produced also vary. Some participants were hoping that the group would provide them with insight (e.g. Case 5: ‘I wanted to know whether you can provide me with some ideas about how I could have avoided being taken in by that inextricable situation and to have managed better’) or were hoping for solutions (e.g. in Case 3, the presenter seemed to expect ideas about how to respond to the desperate mother and her rebellious daughter); still others used the group as a place to reflect on their own
actions and expectations (e.g. Case 2: ‘I will have to investigate this therapeutic rupture’). In Cases 3 and 5, the agent expected the answer coming from the other group members. In Case 2, the others were not so much expected to come up with a solution, but to offer a platform for reflection so that the presenter could find unconscious determinants of his own behaviour. Indeed, working with the unconscious generally is central to BG work. For instance, similar to the requirements formulated to a patient who starts a psychoanalytic treatment, BG participants are not expected to prepare sessions or cases, and are invited to speak freely. Moreover, some group interventions (e.g. the punctuation of slips of the tongue or of remarkable phraseology) aim at the emergence of this different type of knowledge.

The ideas or knowledge ($S_2$) that are actually produced along this way may address the presenter’s dividedness. In that case, they are acknowledged as relevant by the presenter, which is represented by the arrow from $S_2$ to $S$ in Figure 6. This acknowledgement implies willingness to accept viewpoints that differ from the way one was previously looking at the situation, and/or openness to accept contradictions and unconscious motives. For instance, in Case 3, the presenter was probably not ready for such openness, and appeared to be deaf to an animator’s underscoring of a slip of the tongue. As she was talking about the 30-year-old daughter, the GP stated, ‘that child, well, I mean that woman’ but did not react to the animator’s reference to this slip. In Case 2, by contrast, the presenter instantly recognized a co-participant’s suggestion that maybe his ego was also flattered by ‘this patient’s declaration of love’.

However, as the discourse of the hysteric is strongly focused on the signifier, the object $a$ remains in the position of hidden truth: there is no direct exploration/interpretation of how someone’s personal style of dealing with lack determines how he or she behaves professionally. Indeed, a BG differs from a therapeutic group (Balint, 1964). This is guaranteed by certain group rules, such as addressing others respectfully and avoiding confrontations that are too personal, which are watched over by the animators. This also means that for a deeper elaboration on why one consistently makes the same errors or takes the same decisions, a personal therapy might be relevant. At best, BG work brings participants to ‘see’ peculiar characteristics in their own functioning. In terms of Lacan’s theory concerning logical time (Lacan, 2006), it creates what Lacanian psychoanalysts call ‘instants of the glance’ (Moncayo, 2008): moments at which one realizes that the things one does and did are not self-evident, but indicative of subjective choice and preferences. On some occasions though, BG meetings allow for deeper exploration of motives and dynamics that determine(d) a person’s functioning. An atmosphere of openness in the group might facilitate such search for unconscious determinants. However, the format of BG meetings limits such ‘time for comprehending’, which is characteristic of psychoanalytic sessions (Moncayo, 2008). Indeed, in BG groups

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\begin{array}{c}
S_2 \leftrightarrow S_1 \\
a \mapsto S_1
\end{array}
\]

**Figure 6.** The discourse of the hysteric as central to Balint group work.
participants alternate in discussing their own work, meaning that only limited amounts of time are spent on the stories of one participant. Moreover, despite follow-up possibilities in next sessions, case discussions usually only take one session, as a result of which the search for subjective determinants gets restricted. Psychoanalytic sessions, by contrast, are exclusively focused on an analysand’s stories and associations, which allows a more extended ‘time for comprehending’.

**Discourse of the analyst: the motor of BG work**

Whereas stimulation of the discourse of the hysteric was found to be a central aim in BG work, we believe that the discourse of the analyst (see Figure 4) is the support or guarantee of this process. In Lacan’s view, the analyst’s main function consists of enabling the exploration of subjectivity in the discourse of the hysteric: ‘What the analyst establishes as analytic experience can be put simply – it’s the hysterization of discourse. In other words, it is the structural introduction, under artificial conditions, of the hysteric’s discourse’ (Lacan, 2007b: 33). By addressing the subject from what could be apprehended as an empty or open place in the social bond, indicated by the object *a qua* agent in the discourse of the analyst, space is created for the divided subject to speak and to find out which master signifiers have been determining his or her actions. In the formula of the discourse, the latter is represented by $S_{1}$, as the product that is achieved.

Specifically, in the BG sessions, the discourse of the analyst was found to be adopted by both the animators and group members. For instance, pointing at ruptures in the story or underscoring remarkable expressions frequently steered the discussion in a different direction. Examples were found in all of the sessions we analysed. In Case 1, for instance, one animator invited the presenter to reflect on the actual meaning of the signifier ‘faire-part’, which he had been using frequently. In Case 2, for instance, one animator pushed the exploration of the reasons for taking back this patient a little further: ‘What did he [the patient] do for you to say “yes” that day? Or don’t you know? How …? What did he say?’ In Case 4, at a given moment, a participant questioned and at the same time designated the patient’s behaviour as a role she is playing (‘But why does she need that?’ ‘Need what?’ ‘Well, playing that role’). With this intervention, the patient’s suffering and her dividedness were put forward, which steered the group discussion in a different direction, that is, from the description of the patient’s irritating behaviour to the exploration of the underlying dynamics.

The discourse of the analyst is also installed when the group is asked to focus on the particularity of the case, as well as to avoid discussions in general terms. Explicitly probing the presenter’s puzzlement or reason(s) for presenting the case is another example of establishing the discourse of the analyst. If the presenter doesn’t spontaneously assume the position of the divided subject, explicit invitations for doing so were sometimes observed. For example, in Case 5, the presenter hardly formulated self-referential statements, which brought the group to repeatedly probing for her implication in the story (e.g. ‘And how are you yourself situated in this story?’; ‘What is bothering you?’). In Case 3, by contrast, the discourse of the analyst was relatively absent, which might explain why little hysterization was observed during the discussion. Despite multiple
occasions for taking up the discourse of the hysteric, this was hardly ever done, as the group mainly adopted a problem-solving focus and a diagnostic-labelling discourse, which bears witness to adopting the discourse of the university.

In this process of hysterization, both the animators and the group play a facilitating role. However, just like in clinical psychoanalytic work, the actual adoption of discourses largely seems to depend on how the presenter engages in speech. A potential switch in discourse requires in the first place an openness to different discourses. A non-reception of the discourse of the analyst was, for instance, found in Case 3. As one of the animators highlighted a slip of the tongue in the presenter’s narrative in which the GP seemed to present herself as ‘undivided’, this was neglected by the presenter, as well as by other group members, who continued to focus on factual information (e.g. ‘How long did the telephone call last?’).

**Tackling impossibility: discourse interactions**

While the close interactions between the discourse of the hysteric and the discourse of the analyst are crucial to BG sessions, these are not the only discourses at play in BGs. The discourse of the university (Figure 3) was also found to be present at different levels. First, this discourse came to the fore when presenters provided factual information related to the case they present (e.g. about the patient’s history, about the circumstances of the difficulty at stake.). Furthermore, during the group discussion, other participants often asked informative questions and proposed explanations on the presenter’s puzzlement. In both situations, exchanging knowledge and rational thinking are central. In all studied cases, we clearly observed this discourse. It seems that in response to subjective division, BG members often produce all kinds of explanatory narratives. For instance in Case 1, participants provided many suggestions and ideas for explaining the patient’s behaviour (e.g. ‘He might have great expectations towards the doctor’, ‘He is living in a tense situation’). With numerous questions, participants also probed for more information (e.g. ‘How did the consultation continue?’, ‘Was there any violence as a child, with his father?’).

Interestingly, the product of the discourse of the university is subjective division. In the BG sessions, we indeed observed at times that focusing on knowledge results in the eruption of the subjective division, breaking up the chain of knowledge. Rational explanation may be experienced as insufficient, which is why openness for exploring incoherencies in subjective experience comes to the fore. If this dividedness is acknowledged, a switch to the discourse of the hysteric might take place. As indicated previously, this might be facilitated by the discourse of the analyst (Figure 7).
For example, in Case 2, as participants discussed factual information about the situation presented (e.g. the chronology of the events, legal concerns), one member suddenly gave voice to her confusion:

I am confused, because I remember you already spoke about this girl [...] Well, it looked like the relationship between the patient and your colleague was going well. And so, it is really surprising that x time later, well, it has completely changed, all rules are different [...] I don’t understand what could have happened to you so that you accepted to take him back.

The presenter took this remark as an invitation to reflect on the apparent ambiguities in what he had said, and started addressing factors that may have been motivating him.

The discourse of the master, on the contrary, was rarely observed in the BG sessions. This is mainly to be ascribed to the BG rules and principles themselves: a BG is a group of peers (in which any form of hierarchy is avoided) where animators are to watch over the process, but never to act as experts or supervisors (Oppenheim Gluckman, 2006). Moreover, instructing the other how to proceed or to understand a situation is never the purpose of BG work (Lustig, 2006). Nevertheless, occasional engagements in the discourse of the master could be observed. In Case 1, for instance, a participant evoked ‘universally applicable rules’ as a ground for steering one’s actions (‘I think that with regard to “etiquette,” we are not obliged to answer [patients’] wishes and announcements, be they related to marriage, birth or whatever … That’s a certainty, we are dispensed from it’). However, other group members immediately reacted to this by reminding him to restrain from being conclusive (‘You are speaking for yourself, you’re using a majestic plural, but you’re speaking for yourself’ and ‘But I think that everyone has one’s own way of reacting’).

Such switching between discourses is of the utmost importance. If it fails to happen, and the group sticks, for instance, to the discourse of the university, the BG starts to function as a problem-solving group that focuses on answers and solutions, hence leaving out the exploration of subjectivity. The same goes for the discourse of the hysteric. While the latter is central in BG work, a too strong focus on this discourse might reduce a BG to a support group where peers share complaints and concerns. The potential power of BG work lies in the multiplicity of discourses at work and in the possible interaction between different discourses.

It is important to remember that the disjunction of impossibility is both what makes the discourses fail, and what allows for switches between discourses. As mentioned before, these switches seem to be part of the core of BG work. Switching between discourses tackles the initial puzzlement by moving the impossibility experienced in one discourse to a different place in another discourse, which results in a reframing of the puzzlement. Several elements were found to contribute to this dynamic. First, the overall structure of BG discussions stimulates different types of reactions. Generally, after the case presentation, participants ask the presenter clarifying, information-generating questions. This implies engagement in the discourse of the university, where knowledge and understanding are central. Subsequently, once basic information on the case has been shared, the group usually engages in a more free associative circulation of ideas and fantasies, which bears witness to engagement in the discourse of the hysteric. Apart from
this generally observed structure, discussions are often not linear: there is no aim of reaching a final synthetic conclusion, and there is always the possibility of returning to previously expressed ideas, utterances or suggestions. For instance, in Case 5, one animator came back after some time to the remarkable words the presenter had been using: the patient had ‘dismissed’ her and she was ‘convoked’ by the patient. While these words remained unnoticed at first, underscoring them invited the presenting GP to further explore the way she experienced the relationship with the patient. Finally, participants also literally switch positions across different sessions: sometimes they present a case; more often they merely react on cases presented by someone else.

The end of the session: the potential transformation of the initial puzzlement

Most sessions end without a conclusion or solution, nor with a ‘correct’ way to see the case, which is in line with what Balint (1964) intended. Considered from Lacan’s theory of the discourses, this might indicate that the group acknowledges the disjunction of impotence, which separates (the position of) the truth from (the position of) the product and which is inherent to each of the discourses. However, switching between discourses might be a way of dealing with this impotence. At best, switches between discourses in BG sessions produce bits and pieces that can be useful to the presenter: different points of view on a case, ideas on how one might react differently, a feeling of relief around issues one experienced as problematic, and so on. Where the universalizing discourses (the discourse of the master and the discourse of the university) are often dominant in medical practice, their more particularizing counterparts (the discourse of the analyst and the discourse of the hysteric, respectively) can unfold in BG meetings.

Indeed, following the presenters’ initial puzzlement, a change in the three facets of puzzlement might be produced. For instance, in Case 1, the presenter’s initial ‘indefinable malaise’ was reframed as ‘culpability’. Some of the elements that possibly determined the patient’s expression were clarified, and aspects of the presenter’s own implication became apparent as well. BG discussion might also affect the presenter’s preparedness to act, as is apparent in Case 2: whereas at the beginning of the session the presenter wondered how to get rid of the patient without too much violence, he stated ‘having more elements that make him want to keep the patient’ near the end of the session. Frequently, a clearly notable affective relief was observed, which can be ascribed to the symbolization of affects. This, for instance, was very apparent in Case 4. While at first the presenter’s frustration about the situation and the patient came to the fore, the affective relief near the end of the session was clearly perceptible. Eventually, the work during the BG session might help the presenter to take up the discourse of the master again whenever necessary in clinical practice, with the GP being more at ease in his professional role.

Discussion

Analysing five BG sessions through the framework of Lacan’s theory of the four discourses enabled us to shed light on the process of BG work from a specific theoretical angle. While a confrontation with the disjunction of impossibility was often found as the
ground for presenting a case in a BG, the focus on hysterization and the interaction between discourses appeared to shape the group discussions. This interaction might result in creating bits and pieces of new knowledge, focused on the particularities of the case. A BG might be apprehended as a transitional space where elements that don’t fit the habitual work-related discourse can be received and explored in order to take up every day clinical work again. As the discourse of the university and the discourse of the master often dominate GPs’ everyday practice, a BG might provide a dispositive where that which is usually kept under the bar (i.e. the divided subject) can be explored. The focus on the work with subjective division appeared to be crucial in BG work. GPs are not only scientifically trained professionals with extensive knowledge on medical issues, technical expertise and clinical skills, they are also human beings who are affected by their work and who can sometimes be surprised by how they act or, in relation to some patients, experience difficulties in acting in a way they deem appropriate. Specific BG procedures, such as the absence of case preparation and the incitation of free associative speech, seem to stimulate access to their subjective dividedness. Acknowledging the unconscious, in the dynamic psychoanalytic sense of the word, is one of the features that clearly distinguishes BG work from other types of continued medical education.

In order to allow for this process to take place, a special and often difficult task is assigned to the group animators. On one hand, animators have to install a structure where subjective division is recognized and challenged, that is, where participants are invited to talk about their own subjective division and to engage in the discourse of the hysteric. On the other hand, they need to protect participants from ‘wild interpretations’ by other members and to watch over the safety of the group. They balance between challenging group members to transcend their established way of thinking on the one hand, and helping them to respect each other’s personal style on the other. Therefore, we believe that Lacan’s discourse theory, and more specifically his focus on discourse disjunctions and discourse interactions, might offer animators a framework for reflecting on the process of BG work. From a Lacanian point of view, we recommend BG animators to facilitate interplay between the discourses in which particularity comes to the fore: the discourse of the analyst and the discourse of the hysteric. Moreover, by pointing at the importance of discourse switches, this framework also allows to see in what ways BGs differ from problem-solving groups (focusing on the discourse of the university) and support groups (focusing on the discourse of the hysteric).

By exploring and discussing cases in BGs, participants can become more sensitive and flexible in the work with patients (Balint, 1964). Moreover, by addressing their own subjectivity, BG participants can start to be more sensitive to the patient’s dividedness. Indeed, we observed that, as a result of having discussed a case, presenters had more complex ideas about their patient. However, the potential effects of BG participation on doctors and patients need further study. This article especially focused on the process of BG meetings. Their outcomes and effectiveness deserve a separate study.

In conclusion, the findings of this study moulded our understanding of the process of BG work and pointed out its specificity. We argue that elements of this study may guide BG leaders in their work and inform professionals responsible for organizing (continuing) medical education about the specificity of BG work.
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Notes
1. An English translation of this Seminar is available and is titled ‘The Other Side of Psychoanalysis’ (Lacan, 2007b).

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