

# The History of Training and Research in Balint-Groups

by Enid Balint-Edmonds, F.R.C.G.P.

Psychoanalyst, London

The aim of Balint-groups has changed very little, if at all, over the last 20 years. Changes, however, have occurred in the techniques which the general practitioners study in the groups, and which I will describe. It is important, at this stage in our work, at this Conference, that I should describe them. Many doctors may be surprised at how *little* our thinking has changed more than at the way in which it has changed. I do not think this is due to our inflexibility.

What is general practice like? We all know, but Andrew Elder<sup>4</sup> writes, 'It is a world where the doctor is frequently in the dark, getting glimpses of his patients from time to time, being careful not to find out too much, being content to find out the right distance for the patient and for himself. Sometimes taking the initiative, and sometimes needing to be more restrained and to wait.' If a doctor thinks that this task is one that he would like to undertake, and that it is not too far from his ideas about general practice, a Balint-group should be able to provide the means by which he can learn to do so.

I am assuming, of course, that such a doctor would be well trained and continue to be interested in traditional medicine all of his professional life, because without that none of the ideas I will be talking about have their place in medicine, or can be used reliably.

Although I am not medically qualified, I can only feel the freedom to think about the doctor/patient relationship in the way I do in a group of doctors who value the practice of traditional medicine and feel at home in it. They can then, also gradually feel at home with the less — so far — well-defined aspects of their patients' illnesses and the treatment of them which I will try to describe, and which are at the centre of the research undertaken by the Balint Federation.

Before proceeding, let me tell you briefly how we started, although most of you will have read papers about it and will, therefore, be as aware of the history as I am myself! In 1949 Michael Balint led a group of non-medical professional workers at the Tavistock Clinic — a mixed group started by myself in 1948 with the aim of trying to understand and work with people with marital difficulties. We then decided to start working with general practitioners using the same techniques we had developed during the previous work. At this time, at the beginning of the National Health Service, general practitioners in England were under some strain and many did not seem to get the satisfaction they should from their work. Michael, whose father had been a general practitioner, wanted to find out why this was, and we

started what he called then, and what we still call, research-cum-training-seminars for general practitioners. These were held at the Tavistock Clinic where he was a Consultant. I joined him from the start, and for 20 years until he died we worked together in these seminars. The aim is clear from the title: it was to find out what general practice was like, and what was wrong with it, and whether we and other psychoanalysts with our particular way of looking at human relationships and with our inward-looking experience in working with the unconscious mind, could help to throw any light on the subject.

Furthermore, new techniques and methods of working might have to develop; techniques which could be used by general practitioners. We worked in groups of about 8-12 general practitioners, and one or two psychoanalytic leaders, who stayed together for a minimum of two years, meeting once a week for two hours, discussing patients who were currently presenting difficulties, who did not get well as they should and were causing their doctors headaches. The groups studied in detail, without the use of notes, what a general practitioner told the group about a patient with whom he was having difficulty, giving special attention to the relationship between the doctor and his patient, often at one particular consultation. We discussed human relationships: not in general terms, but one particular relationship at one particular time.

Some doctors, having started to think in a different way about their patients and themselves, wanted to go on doing so after the end of the two years. Others had enough after a shorter time. Later, we devised what we called a Mutual Selection Interview so that the leaders of the groups, and the general practitioners who wished to join them, could find out what was on offer. The leader could see if the general practitioners were likely to fit in and be satisfied with the work of the group, and the general practitioner could see what the leader was like and how he spoke about his work, and what he needed. After we started having these interviews there were very few doctors who left before the end of the two-year period, and hardly any who left disappointed soon after the group started<sup>3</sup>.

As I have just said, right from the start of our work, we found ourselves studying the relationship between one doctor and one patient at one time. Why was one patient difficult, another not? Our method of work and our research method was stable: it consisted of discussions of a doctor's difficulties with, and his relationship with a patient in a structured setting. With the same leader, the same doctors, in

the same place discussing patients over a longish period. Verbatim transcripts were made of each meeting. Some structured information was taken from the scripts by the group itself, at the following meeting. Headings were devised so that the same data would be followed. We called those headings 'forms'. We still use them, and adapt the headings (i.e. data we wish to observe and follow) as the research develops.

We found the use of the doctor's own notes — the ones he made while seeing his patient, or after he had left — distracting during the discussion itself, and we soon adopted a method based on the method of supervision used by Hungarian psychoanalysts. This was to encourage students to speak freely without notes, contradict themselves if necessary, have second thoughts, remember things they thought they had forgotten; so that a complete picture in which the feelings of the doctor himself emerged about the facts he was reporting. So the actual reports were without notes, i.e. no notes were used while reporting. However, as I have said, at the beginning of each meeting, sometimes we left it for a week or two, the verbatim transcripts were read of the last meeting and 'forms' filled out to guide our thoughts in a particular direction — a direction which was the basis for our current research.

To those who have never worked like this, with an observer leader trained to observe in a particular way; one who can tolerate the absence of a consistent story for a time and *use* the muddle rather than try to discard it, this method may sound very strange and unscientific. It consists, as I have just said, of amassing facts and the feelings about the facts at the same time. Our work is based on the idea that human beings, whether doctors or patients, unconsciously defend themselves against certain thoughts and ideas. They try to get things in order, and this often involves leaving out facts and the feelings about them. The story seems clear, and the doctor when reporting is unaware that it is incorrect. In our kind of discussion and reporting such omissions and falsifications come to light without embarrassment.

A trained observer, possibly a trained psychoanalyst or someone who has worked with one for a long time, is needed to help piece the data together; who has the ability to listen in a certain way. Hunches, fantasies and feelings should be expressed without embarrassment but not treated as sacred; the work of the group and of the doctor in charge of the patient is to see if what is said is true — to examine on what such fantasies and hunches are based — so that the doctor can, if appropriate change his ideas about his patient. This is all done in a stable setting. The methodology does not vary, and each doctor gets accustomed to looking at his, and his colleagues' work with the same strictness and freedom.

We still use the same method, but do we listen in 1984 in a different way for different things? Have we changed? We are, perhaps, even less anxious to make a coherent story, to make 'sense' early on in our work. We still make a working diagnosis (not an overall

diagnosis as we used to call it), but we are now more observant of *changes*, however minute, which take place in the doctor/patient relationship, in the doctor's feelings about his patients, in the patient's complaints and even changes which take place during one consultation. We are particularly careful not to fit new observations into old patterns where they are inappropriate.

Early in our work we sometimes spoke about our ability to train general practitioners to do some form of psychotherapy, and we blamed unsuccessful results on the fact that our doctors did not have much experience in this field. It was assumed then that had the 'psychotherapy' been better, the patient would have been cured. The most common basis of any form of psychotherapy, it was said at the time, is an understanding of the patient's real problems. It was, therefore, thought that had they been understood the patient would have been helped. By 'real problem' was meant the underlying cause of the patient's illness.

However, even as early as 1961 we had an early change in thought — we questioned whether we were right to use the idea of 'diagnosis in depth', or whether we should talk about 'going in deeper with our patients'<sup>2</sup>. We felt that our analyst colleagues would already feel that the various diagnoses in depth that we were reporting were rather superficial when compared with what analysts would accept as deep.

Nevertheless, we decided to stick to the word 'depth' as we felt at that time, that the examinations we were interested in must be oriented so that they should proceed from what the patient tells us towards what lies beneath what he tells us. Depth, therefore, was thought to be taken as denoting the direction and not necessarily the level reached. I now often think it is unnecessary, and can be unhelpful at any given time, to try to discover what a patient thinks is the cause of his present symptom or unhappiness. As I have already said, in general practice the patient's feelings in the present, and the changes in them, seem more important and more reliable.

All our work is based on one human being, a professional, understanding not only intellectually, but in other ways as well; based on traditional medical teaching, and by identification. Intellectual understanding alone, is not enough. To understand, it is necessary to listen to what one does not understand; watch and notice the human being one is talking to, as well as one's self at the same time, and so to be able to identify. It is necessary to notice, and watch changes in one's ways of reacting to the other person.

Identification depends more on a willingness, or even a desire to understand, than an ability to sympathise. However, once an observer has identified himself with someone or something, he will find it difficult to feel objectively about that person or thing again. But he must first identify, and then he must withdraw from that identification and become an objective, professional observer again. The identification must have a biphasic structure. In addition, a doctor must be able to respond correctly, without too much delay.

Scientists in other fields describe how difficult, or even impossible, it is to observe anything without influencing the object observed. No two observers will see exactly the same thing. The value of Balint-groups is to facilitate observations.

Here is a case: it is a follow-up of a woman patient who had been seen and reported to a group almost a year before, soon after her first child was born. The baby, a girl, was suffering from a severe cough. The doctor had the cough 'investigated' but it persisted, and the patient continued to come to see the doctor complaining that she could not stand being kept awake at night any more. She must get back to work because she was not good at being a mother anyway, and she wanted to carry on with her career. Her husband was no help, either.

The group had discussed this case the year before, and had thought the patient was a rather over-dominant, masculine woman (although there was no real evidence of her being masculine, other than her not being able to cope with her first child and wanting to go back to work). The working diagnosis was of a dominant woman with a weak husband who was presenting her child with a cough and who bullied her doctor.

At the follow-up, however, the question of whether the woman was dominant came under review. Could it be taken for granted on the grounds that the doctor fitted in with her requests for frequent examinations of the child, and anyway, the group asked this time, was this diagnosis of any help to the doctor or the patient? Most of the group were doubtful, but did not know where to turn, and then slowly began to look at the interview itself which the doctor was asked to report in greater detail.

The doctor then told us that he thought the patient was very lonely. She had moved quite far from her home when she got married two years before, and the picture of the dominant, unattractive woman disappeared and we seemed to have somebody else as a patient. The doctor began to feel more at ease when he talked about her, and said how lonely it must be for her; how awful it was for her to have a child and to have no one to share it with. He got in touch with feelings in himself, and identified with the patient.

But there had been no biphasic structure in his identification with which the group were able to help him. The patient was then able to feel less alone with her husband, less lonely; let her husband share.

I will give another case to illustrate this point. A doctor reported on the case of an old patient of his, who he had known for several years. At the age of 36, she was dying of cancer, having had all the possible treatments, and she was now so distressed, and so unwilling to go back to hospital that her general practitioner had advised that she be left at home until she died. The hospital had agreed to this.

The doctor, however, then found it was very difficult for him to visit his patient and reported this case to the group because of his difficulty in visiting his dying patient. The group was very subdued, and made all sorts of excuses for the doctor, and could well

understand how, because he could do nothing for her, he could not bring himself to visit her; that he was very busy, and so on, and so on.

The case was discussed for quite a long time before someone said he was sure the doctor wanted to visit the patient but was so identified with her he could not face it. The doctor agreed: Yes, he wanted to go but he could not face the way she looked, although when he saw her he did not mind at all. In fact, when he got into her bedroom he was very pleased to sit on her bed and to hold her hand, which she put out towards him when he entered the room. He then saw her as a separate person whom he could be with: relate to. This doctor needed to realise that the patient was a separate person, who did not expect anything of him he could not give, and was glad to have somebody with her who could accept the fact that she was dying, and that she did not look too frightening. There was no need for him to say anything special. We will come back to this.

When did we begin to observe the changes in our focus of interest? Changes in the techniques we were trying to devise for general practitioners? It is difficult to say, but a new appraisal started in January 1966, when a research team consisting of ten general practitioners and two, and sometimes three, psychoanalytic Leaders met at University College Hospital under the leadership of Michael Balint and myself. The group ended in 1971, a year after Michael died.

A book, based on the research in the group, was published in 1973<sup>1</sup>. The ideas that were structured during these years had already been in the minds of both of us for some time. In his introductory chapter called 'Research and psychotherapy', written just before he died, Michael wrote, 'in spite of all our efforts so far to create a technique suited particularly to the setting of medical practice, the 'long interview' has remained a sort of foreign body in the general practitioner's normal routine.' That is to say, the psychotherapeutic type of interview, though used, was not really suitable. Also, I want to add the kind of diagnoses we were making were too static, not fluid enough.

The new techniques that we were aiming at had to be based on a reliable understanding of the patient's individuality, and particularly of the developing relationship between the patient and the doctor, that is to say on *processes* rather than *states*, and what at one time seemed impossible, the time needed for these techniques had to be compatible with the routine 10-15 minutes that the average patient gets in a medical practice. We encountered severe difficulties in this group, the principal one was, and I again quote from Michael, perhaps caused by the realisation that their old, well-proven methods had to be given up, or at any rate considerably modified, partly because of the new conditions, and partly because we were not sure whether the results in the long run gave the doctor, and therefore the patient, sufficient satisfaction. In the old method which we were giving up, the doctor had responsibility for understanding not only what the patient tried to convey to him, but why the patient had become the way he was; and although he was as interested as we still were to recognise omissions and

distortions in the patient's story, his aim then was to solve something which is, after all, the traditional role of the doctor. But in the new technique the therapist's role was to tune in to the patient and to sew what it was like both for himself and for the patient, and what changes occurred and how varied and inconsistent his feelings and the stories that he got were. The need here to identify and then withdraw from the identification is paramount.

The techniques which arose out of these ideas described in 1973 was called the 'Flash', which consisted of a moment of mutual understanding between a doctor and his patient which *was communicated by the doctor to this patient*. It was not an understanding about the patient's past about which the doctor was very likely completely aware, but was usually about something in the patient's current life and which was reflected in the relationship with the doctor for a brief time. These episodes were very hard to follow up reliably, but when they have been followed up changes do seem to persist in the doctor's feelings about the patient, but we have not been able to observe reliably in what way the patient responded to them. It appeared that they were sometimes brushed aside; not referred to again.

Our current research is focused on a technique similar, in some ways, to the flash technique: but different in important ways. As I have made it clear throughout this paper, this time we are concerned with making observations about changes that take place in a doctor's feelings about his patient, and a patient's feelings about his doctor; changes which *are not communicated at the time by the doctor to the patient*, at the time they are noticed. This is crucial. In the 'flash' technique, when a flash occurred the doctor communicated his thoughts and feelings to the patient. Nowadays we prefer to wait and see what happens to a patient when a doctor's feelings change, sometimes suddenly, about him.

Here is a case: A woman in her late sixties, married to a man eight years younger than the patient. This woman had come complaining of depression for many years, for which she had been given pills which she said had always helped her. The doctor changed the medication from time to time, and each time the patient seemed satisfied, although she came back again with the same symptom. One day, however, the patient came as usual — or so it seemed — and the doctor found himself asking her whether there was something that was particularly wrong. The patient said her husband had a mistress, but this kind of thing had happened so often before she did not think it had any particular significance, and she spoke in a way that did not make the doctor feel that she was particularly troubled by it; but at that time the doctor found himself seeing the patient as an old woman with a deaf-aid (which he himself had arranged for her some years previously); a woman who felt that her life was over, with her husband who would never want her any more; that there could be no more sexual relationship between them, and that she was finished.

Actually, it was the doctor who felt all of this, and who reported these feelings at some length to the group. We did not know what the patient felt. In this interview the doctor had not said anything about this to his patient, but he was shocked. He did not suppose that the patient was aware of any of this at the time, but the group felt that probably the patient had felt old and useless many times and that it was the doctor who had only just picked it up. Perhaps the patient felt better because of this. The patient returned after three weeks and said that she was depressed, but for the first time said that the pills were no good and that there was no point in her having any more. She had come because she was going on holiday with her husband, and she wanted to talk to the doctor first about it, but she did not want to use the pills. The patient said she was terrified that she was going to spoil the holiday. Her husband had planned it after giving up his relationship with his girl friend, and this made the patient particularly anxious that she should not spoil it; that the better relationship which seemed to be growing between her and her husband should not be spoiled by her being so awful, and depressed, and useless.

In this interview the patient showed something which could have been caused by the doctor's feelings in the interview before, when *he* had felt despair for her and fear for her future, but had said nothing. We could say that the patient had 'unloaded' her feelings into the doctor and in consequence she had become partially free of them and was able (instead of being passive about them) to become active as if free for the time being and not passively having to accept her fate. If this was so, this was a major change. The idea is that what the doctor 'took in' during that interview and afterwards had enabled the patient to be free enough to take the initiative at the next interview (by not accepting the pills as usual); and also to behave differently, more actively, less like a victim with her husband in the meantime. The doctor, having had insight into the patient's ideas about herself (not about what she was like, but what she *felt* she was like), enabled her to come alive and to rid herself, temporarily at any rate, of her heavy, passive, depression. The doctor had, so to speak, taken in what the patient projected into him and had held on to it for a time; had not immediately handed it back to the patient in the form of an interpretation. At the next interview, however, when she came saying she did not want the pills but did not want to be depressed, he was able to respond appropriately, having by that time got rid of the projection, i.e. of the patient's depression. He did not, of course, at that time, say 'you are an old, deaf, woman and there is no hope for you', but spoke about the holiday and the processes that were going on inside the patient, at that time.

There have been other cases, as I have already shown in this paper, which confirm our ideas about this particular kind of tuning in or, one could talk about it in terms of the doctor's containing a projection from the patient and the effect it has on a patient when the doctor does not communicate, does not interpret, but holds on to feelings which a patient has put into him, and with which for a short time he totally identifies

with, but which he is then able to distance himself from. He knows what it is like to be the patient but also is able to see that it is not all the patient has inside him.

The doctor must become aware of the feelings the patient has, and be ready to hear what the patient says at the next consultation as well as the one in which she projects something in to *him*, or take in other projections. The patient can then become the active one, and this is not deflated by seeing something about himself passively; or, if that is too threatening, to fail to take it seriously at all. The patient can change once the doctor knows what it is like to feel the way she does. She can then tune in to other parts of herself. But she cannot change, sometimes, by being told that she should change, or being told what she is like. She is given the freedom to change in this way.

This brings me back to another reason why we run our groups the way we do; it is so that the doctors in the groups can be active, not passively receptive, either of their own feelings or to what the leader says; so that they can talk freely about their patients and their feelings about them, at one particular moment, in one particular session, bearing in mind that this is almost certain to change; in so doing they can get in touch with feelings in themselves about which they have been unaware, and which may enable them in due course to understand something about their patients which they would not have been able to do had they been out of touch with their own feelings and the seriousness of them.

To take the responsibility for their own feelings and thoughts, to realise how hard it is to observe them reliably, and how easy it is to miss what other people say, are some of the things that doctors in Balint-groups get to know about. Balint-groups allow such processes to occur, allow doctors to realise how hard it is to observe, particularly when the observations are not stable. In this work activity of a special kind is released in the doctors, a kind of psychic activity. Liveliness, not passive acceptance; observations, not instructions.

### References

1. Balint, E., and Norell, J. (1973) *Six Minutes for the Patient*. London, Tavistock Publications.
2. Balint, M., and Balint, E. (1961) *Psychotherapeutic Techniques in Medicine*. London, Tavistock Publications.
3. Balint, M., Balint, E., Gosling, R., and Hildebrand, P. (1966) *A Study of Doctors*. London, Tavistock Publications.
4. Elder, A. H. Book in preparation.

Paper read at the Sixth International Balint Conference at Montreux, 1984