

BALINT TRAINING

THE DOCTOR, HIS PATIENT AND THE ILLNESS

MICHAEL BALINT, M.D. 1953

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The Use of Group Methods

The mainstay of our scheme is the week case conferences, about ten to twelve in each of three annual terms. To secure intensive participation and, on the other hand, to obtain sufficiently varied material, we have found it advisable to have groups of about eight. In addition, to the conferences, we offer any doctor who asks for it individual supervision of his cases, i.e. about an hour per week of “private discussion.”¹

I have already pointed out that we try to avoid, as far as possible, the ever-tempting “teaching-being-taught” atmosphere. Our aim is to help the doctors *to become more sensitive to what is going on, consciously or unconsciously, in the patient’s mind when doctor and patient are together.* This kind of “listening” is very different from “history-taking,” and we encountered considerable difficulty when trying to free doctors from the automatic us of this kind of approach. The main difference is that history-taking is concerned almost exclusively with objective events, or with events that can easily be expressed in words; and towards such events both doctor and patient can adopt a detached, “scientifically objective” attitude. The events that we are concerned with are highly subjective and personal, often hardly conscious, or even wholly beyond conscious control; also, as often as not, there exists no unequivocal way of describing them in words. Nevertheless, these events exist, and, moreover, they profoundly influence one’s attitude to life in general and still more so to falling and being ill, accepting medical help, etc.

It may safely be said that these events, happening all the time in everybody’s mind, are only in part sensible adaptations to the ever-changing environment; to a large extent they are governed by almost automatic patterns, originating mainly in childhood but influenced by emotional experiences in later life. Our first task was to awaken in the doctors an awareness of these automatic patterns, and then to enable them to study in greater and greater detail how they influence the patient’s attitude towards his illness, and on the other hand how they colour or even determine his relations to any human being, and especially to his doctor.

Another factor affecting the patient’s developing relation to his doctor is the doctor’s response, which is also partly governed by automatic patterns. The interplay of these two sets of patterns, whether and how they “click,” to a large extent determines the efficiency of any treatment. Its influence is less important in short-lived, acute illnesses, but in chronic illnesses it is almost crucial. In order to be able to “click” better, and with more patients, the doctor must have a wide choice of responses, which means that he must become aware of his own automatic patterns and gradually acquire at least a modicum of freedom from them.

¹ In 1963, Balint began to doubt the value of “individual supervision.”

The Limited though Considerable Change of Personality

Intellectual teaching, however good, has hardly any effect on this process of liberation and general easing up. What is needed is an emotionally free and friendly atmosphere in which it is possible to face the realization that one's actual behavior is often entirely different from what was intended to be, and from what one has always believed it to be. The realization of the *discrepancy between one's actual behavior and one's intentions and beliefs* is not an easy task. But, if there is good cohesion between the doctors in the group, the mistakes, blind-spots and limitations of any individual member can be brought into the open and at least partially accepted by him. The group steadily develops a better understanding of its own problems, both collectively and individually. The individual can more easily face the realization of his mistakes when he feels that the group understands them and can identify with him in them, and when he can see that he is not the only one to make them. Moreover, it takes only a short time for the group to discover that the technique of each member, including the (psychiatrist)² group leader, is an expression of his personality, and that the same of course applies to his habitual mistakes.

Crises

Admittedly crises occur from time to time when one or other member finds it difficult to accept the full implications of some of his ways of handling his patients, or the realization of some facets of his personality that he has previously been only dimly aware of. These, however, can be borne, as they are also group events and do not solely concern the individual. It has been easy to describe this state of affairs, but it is rather difficult to explain its dynamism. So long as the mutual identifications of the members are fairly strong, any individual member can face strains, because he feels accepted and supported by the group. His mistakes and failings, although humiliating, are not felt as singling him out as a useless member of the group; on the contrary, he feels that he has helped the group to progress, using his failings as steppingstones. *Crises may occur when there is some tension between one or other member and the rest of the group* which the leader has not detected soon enough and, instead of re-establishing good cohesion, his criticism may help to widen the gulf.

Signs of this isolation, or tendency to isolation, and the accompanying touchiness can be regarded as equivalents of what psychoanalysts call resistances. On the one hand, they are premonitory signs that some major personal attitude of the individual is being tackled in the group situation; on the other hand, by the way in which the isolation is achieved and maintained, they show what the problem is. They represent very valuable material for studying inter-personal relations, and their full realization is necessary for the re-establishment of a workable cohesion.³

² Of course this is no longer true and in this country the majority of groups are led by psychologists and or family physicians.

³ Balint is not encouraging interpreting this understanding to the group. Understanding by the leader helps establish an atmosphere in which the group can work together better in the face of this kind of storm.

If such crises occur too often, or leave bitter resentment behind, it is a sign that the pace of training has been too exacting and that the group has been made to work under considerable strain for some time. It is an equally ominous sign, however, if no crises occur; it means that the sensitivity and grasp of the group are not developing and that the group and its leader are in real danger of degenerating into a mutual admiration society in which everything is fine and the whole group consists of nice, clever, and sensible people. It is a fact that the acquisition of psychotherapeutic skill is tantamount to the discovery of a number of hard and unpleasant facts about one's own limitations. This unpleasant strain must be faced, and the group develops as long as it can face it, and stops developing as soon as it tries to avoid it. It is the task of the group leader to create an atmosphere in which each member (including himself) will be able to bear the brunt when it is his turn to bear it.

.....Although every report and case conference is definitely a strain and an effort, the result is nearly always a widening of one's individual possibilities and a better grasp of the problems.

Importance of Timing

One of the most important factors in this kind of training is timing, which in the first instance means not being in a hurry. It is better to allow the doctor to make his mistakes, perhaps even to encourage him in them, than to try to prevent him from making them. This sounds rather foolhardy, but it is not; all our trainees have had considerable clinical experience, and this "sink or swim" policy was justified. Apart from not undermining the doctor's confidence and dignity, it had the advantage of providing ample material for discussion, as everybody was seeing patients all the time and was anxious to report his findings and discoveries, his successes and difficulties.

If the timing is good enough, the doctor feels free to be himself. Gradually he becomes aware of the type of situation in which he is likely to lose his sensitivity and ease of response, or, in other words, to behave automatically. Meanwhile the reports of other doctors have shown him what other methods might be adopted in similar situations. The discussion of various individual methods, the demonstration of their advantages and limitations, encourages him to experiment. (One practitioner announced the result of such an experiment this: "I have done a real 'Smith' in this case-and it worked," meaning he had adopted the attitude he felt Smith usually adopted.) Every such experiment means a step towards greater freedom and improved skill.

Attitude of the Group Leader

Perhaps the most important factor is the behavior of the leader of the group. It is hardly an exaggeration to say that if he finds the right attitude he will teach more by his example than by everything else combined. After all, the technique we advocate is based on exactly the same sort of listening that we expect the doctors to learn and then to practice with their patients. By allowing everybody to be themselves, to have their say in their own way and in their own time, by watching for proper cues-that is, speaking only when something is *really* expected from him and making his point in a form which, instead of prescribing *the* right way, opens up possibilities for the doctors to discover by themselves *some* right way of dealing with the patient's problems-the leader can demonstrate in the "here and now" situation what he wants to teach.⁴

⁴ Role modeling as an important teaching technique

Obviously no-one can live up to these exacting standards. Fortunately there is no need for perfection. The group leader may make mistakes-in fact he often does- without causing much harm if he can accept criticism in the same or even somewhat sharper terms than he expects his group to accept. This must be watched very carefully, and any hesitation by the group in exposing the leader's mistakes must be pointed out. Obviously this freedom cannot develop if the leader tries to hedge or to explain away his failings. It is a wholesome sign if the group can run him down, even if they have some fun at his expense, provided they can do so without rejecting his or turning hostile to him.

The Doctors' Counter-transference

I mentioned above that the most important material for our training method was the ways in which the doctor uses his personality, his convictions, his knowledge, his habitual reaction patterns, etc., all that can be summed up by the term "counter-transference."

In our setting this counter-transference has three aspects, and in our scheme we use these three in varying degrees; they are-

- (1) The doctor-patient relationship.
- (2) The doctor-group leader relationship.
- (3) The doctor-rest of the group relationship.

We use the *doctor-group leader relationship* very sparingly, as in the group situation we try to avoid the discussion of emotions of a personal and intimate nature; that is to say, we try to avoid allowing the group to develop into an openly therapeutic venture. Interpreting consistently the ever-present, ever-changing transference feelings of the various participants would focus emotions still more on the leader-as happens in therapeutic groups. In our method we try to avoid this kind of development, although we are fully aware that it is impossible to do so completely. The group leader is unavoidable singled out by his place and function, and a great deal of emotion is centered on him. This fact must be recognized and accepted, but we refrain from interpreting it in detail. The few occasions when we have had in interpret it have been exceptional, and we are uncertain whether or not they could have been avoided by more skilled technique, i.e. by paying closer attention to the counter-transference in other fields.

Nevertheless, the importance of this relationship cannot be minimized. The group leader represents the standards aimed at by the training scheme. Whenever a patient is interviewed by a practitioner, in his mind the group leader is always present. Thus the interview, depending on the practitioner's actual emotional attitude, is conducted in order to show off to the leader, or to prove that he was wrong, or to demonstrate that the practitioner has learnt his lesson and that he can get on well without him, or that his opinion was most valuable and penetrating, and so on. Of course the same emotional attitudes colour the reports presented to the group. Although we are fully aware of these implication, we make hardly any allusions to them Perhaps what we use most often is *the contrasting of the doctor's individual methods with those of his colleagues in the group.*
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In order to enable it⁵ to develop it is essential for the group leader to hold back, to refrain from making his own comments and criticisms until everyone else has had ample time and more to do so. To be able to make a true comment on a involved doctor-patient relationship it is necessary for the listener to allow himself, in his fantasy, to become involved in the situation and then to listen to his potential reactions to his involvement. Because of the ubiquitous resistances this happens rather slowly, and so both the group and its leader must learn to be patient. Even after the participants have learned to listen pretty freely to their internal involvements, experience shows that one usually becomes aware of one's own response in only a piecemeal fashion, and thus time and patience are of the first importance.

This is especially difficult when *the group for some reason is hesitant or is obviously pulling its punches to spare the reporting doctor*. When this occurs the correct technique is to interpret the hesitation or the excessive kindliness of the rest of the group, and not to criticize the reporting doctor. As I have said, this requires a good deal of self-control on the leader's part, especially as it is so tempting to be helpful, understanding, and, above all, constructive. If one gave way to this temptation *one would teach excellent theory, but only at the expense of the training*. The result would most likely be that the promising doctors would gradually grow bored and drop out, and the hopeless ones would admire and idealize the leader, introject his teachings-and stay with him for ever as his faithful and loyal pupils.

It is much more difficult to deal with the opposite situation, when after a report *the group is either hypercritical or blatantly indifferent and unco-operative*. This is usually a symptom only of one of the members having been "singled out," as we call it. There are many possible causes of this strained situation; I shall enumerate a few, but I am fully aware that I shall not deal exhaustively with the problem. The most frequent is that the "singled-out" member is out of step with the group in his development, especially in regard to the stage reached by his emotional understanding of the doctor-patient relationship. He may be either well ahead of, or far behind, the rest; the fact is that either causes great irritation and can be tolerated only with difficulty by the rest of the group. There are various methods of dealing with this situation, all amounting to a kind of interpretation. The leader can demonstrate how the group behaves by his own behavior, which of course should be as far as possible imperturbable, and certainly not irritated. If this is not enough, he can contrast the reporting doctor's work with that of the rest of the group and show in which ways they differ, and what the significance of the difference is. This is usually enough, because it helps both the reporter and the rest of the group to become conscious of their different rates of development and to see the causes of the irritation. In the whole course of the scheme we have not found it necessary to interpret this situation in so many words.

The most difficult a doctor may overstate his initial successes, and omit to report further developments until a crisis occurs. Then he may report on his apparent failure with bitterness, putting the blame on the course. Another symptom may be a doctor's more or less complete withdrawal, his hardly ever reporting cases and restricting his participation to acid comments showing his bitter disappointment in psychotherapy, or limiting himself to sterile, automatic repetition of one and the same comment. For the time being our method of dealing with this situation is to play for time in the hope that the development of the rest of the group will in due course draw the "singled-out" doctor out of his withdrawal. This policy is not too good, not too bad; we have had a modicum of success with it.....

⁵ the group

The Doctor's Counter-transference to his Patient

With the foregoing I have been able to show some of the most frequent problems arising when dealing with two of the three transferences mentioned above, namely, the transference of the doctor to the group leader on the one hand, and to the rest of the group on the other. The main part, however, of the everyday work of the group conferences is concerned with the doctor's counter-transference to his patients. What happens at our conferences is that the doctor becomes aware of-and to some extent even understands-his involvement and personal resistances in his relations with his patient and with the rest of the group. In this respect I wish to emphasize again the importance of timing, that is that the psychiatrist-leader must go with the practitioners, helping them to become aware of the stage their understanding has reached-but he must not be too far ahead of them. Being ahead of them theoretically does not matter much one way or the other. *Being ahead of them emotionally and showing this too early creates a superior-inferior atmosphere in which teaching begins and training suffers.*

If possible, the aim should be to create an atmosphere in which anyone can speak unhurriedly, while the others listen with a free, floating mind, in which some silence is tolerated and time is allowed to everyone to find out what he really means or what he really wants to say. Unexpected things can be said and examined at times without any drama, while at other times they are allowed to cause mirth, surprise, embarrassment, or even pain. But, whatever the group's reaction, the emotions emerging both in the reporter and in his audience must be accepted and evaluated as expressions of unconscious processes activated by the report. Once the doctor is free enough to watch, to experience and finally to listen in the group conferences instead of being anxious about understanding the psychodynamics of his patients, he can start to listen in his patient and himself.

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