Dunleavy, D.L.F. (2022). Experience of the Group Leader, 1976. *Journal of the Balint Society, 49: 72-80.*

JOURNAL OF THE BALINT SOCIETY, VOLUME 49, 2022

Experience of the Group Leader (1976)

D.L.F. Dunleavy [1]

[1] Senior Lecturer in Psychological Medicine, The Royal Victoria Infirmary, Newcastle

I like to think of myself as something of an expert when it comes to running groups. At the outset I was confronted by three difficulties in describing my experience with our seminar in Nottingham. The first problem is that it is still developing, and it would be premature to talk about a number of things at this time. The second problem is that I relinquished leadership three weeks ago on taking up my new post in Newcastle. The third difficulty, however, looms much larger, and those of you who have been members of a seminar will understand my problem. We have developed a very close group-identity and at an emotional level it is almost like betraying a trust when one comes to talk about ourselves to outsiders. There is a part of me which does not wish to share our experience with others, and a feeling of guilt was hovering in the background while I prepared this paper. I have, I hope, successfully resolved some of this conflict, and would now like to describe my personal experiences in three ways. First of all I would like to say how I personally came to have an interest in this type of work; secondly, what I felt I had to offer; and thirdly, to share some of the seminar experiences.

My involvement

I had been intrigued for some time by Erikson's writings on developmental and accidental life crises. He talks of the time when one becomes engaged, when one marries, the first day one's children go to school, etc., as normal developmental life crises. Accidental life crises would be the death of a loved one, one's divorce, possibly a car accident, or a period of severe sickness. At these times of crisis the individual is likely to fray at the edges a little. He is much more vulnerable to other stresses impinging upon him, and the probability of decompensation increases with the number of things he has to cope with at this time.

---

[1] First published 1976. Vol. 5, *Journal of the Balint Society.*
At the time of publication, D.L.F. Dunleavy was a former Lecturer in Psychiatry at the Nottingham University Medical School and a Senior Lecturer in Psychological Medicine at The Royal Victoria Infirmary, Newcastle.

However, although there is a potential for destructiveness at these times, there is also a potential for growth. This idea became linked in my mind with Caplan's work on crisis consultation. His idea, basically, is that minimal intervention at these times can be of major benefit to the individual. I always remember one of his encapsulated statements which I feel I should have framed on the wall of my office. He claims that 'excellence is the enemy of the good'. I understand him to mean by this that we should be prepared to do a little even where we realise much more is called for. If we could do this little amount of work at times of crisis our efforts would be rewarded to a much greater extent.

As a psychiatrist, I am also aware that we deal with only a small percentage of the psychological disturbance which exists at any one time in the population. In fact, it has been shown that referral to psychiatric agencies is very idiosyncratic, and it is very hard to tease out why one person ends up seeing a psychiatrist, and another does not, although both may have the same symptomatology. We are also much more removed from people, while the general practitioner is on the spot. Unfortunately he is all too often literally on the spot! If he could be trained to be more psychologically aware of current life stresses and how they act on the individual, his intervention at these times of crisis would hopefully be more effective. The Balint type of seminar seemed to me to be the best medium for developing this expertise.

What did I have to offer?

I had been involved in therapeutic groups in Edinburgh over a four-year period. For two and a half years of this time I had been supervised in a group by Dr J.D. Sutherland, who has been a great influence on my orientation. He has been concerned for some time that psychiatrists may not be involved where they are most needed. He feels that we should act as consultants to the people who are performing caretaker functions in society. In other words, we should be talking

about their case work with general practitioners, social workers, and other community workers. There is no doubt that there is a great demand for this form of consultation from people who work in the community, and also from their clients. The latter often speak through the bulletin of the National Association of Mental Health, 'Mind', and what they have to say makes alarming reading. Psychiatrists, because of their field of work, should have an expertise in this form of consultation, but unfortunately it is true to say that many of them do not.

As an academic, I am also interested in small-group teaching and, fortunately, much of the undergraduate teaching in Nottingham occurs on the small group-seminar principle. Dr Skinner has described how he was interested in starting a seminar in Nottingham (p. 18), and I felt that I might be able to act as a resource person for this group. It was fortunate for me that I happened to be in the right place at the right time, as the intended seminar combined my interest in teaching and doctor/patient interactions.

Personal experience of the group

I will discuss this under two broad headings: firstly general problems that remained with me throughout the seminar's duration and secondly, specific problems that arose at different stages in the development of the group.

General problems

a) Isolation

The first thing I would like to comment on, in my personal experience of the group, was the experience of isolation. I did not have a co-leader, and in retrospect this was clearly a mistake. There were many occasions when I did not know what was going on, and on other occasions so much was happening that it was impossible for one individual to absorb it all. It is very necessary to have some sort of sounding-board where one can discuss one's ideas, or possibly have one's own

feelings reflected back. Most writers on group work talk of the absolute necessity for ongoing supervision and consultation. This is one of the problems, of course, of any type of work in the psychotherapeutic field outside London. There are few people with whom one can discuss one's involvement, and I grasped avidly at any opportunity for discussion when I met friends who were involved in psychotherapy.

b) Anxiety

I had realised from my experience in therapeutic groups that the leader often feels anxious about his abilities. This of course may be a very realistic appraisal of one's own talents, but one also becomes very much involved in group processes. When the group is in a despondent stage one becomes 'infected' with feelings of hopelessness. One doubts one's own ability and questions whether one has the skill to deal with particular situations which are being presented. One feels that here are people who are giving up their valuable time and are eager to learn, and one has nothing to impart to them. Fortunately my natural buoyancy reasserted itself at these times, but there were occasions when I went to the group with reluctance, or went home biting my nails. It is not very pleasant having your identity threatened, and here again, discussion would have been helpful.

Specific problems to the Group

a) Name

This caused a great deal of frustration in the initial stages of the seminar, and illustrates once again some of the bureaucratic nonsense to which Dr Skinner has already alluded. We were billed on the noticeboard in the Postgraduate Centre as 'Psychiatric Tutorial'. This annoyed me considerably as I did not feel that my function in the seminar was in any way connected with teaching psychiatry. Neither did I feel that I was going to teach psychotherapy directly. I was interested only in looking at the doctor/patient relationship as it was expressed in ordinary,

everyday general practice, and I had been at great pains to spell this out in the prospectus which was distributed before we established the seminar.

After some exchanges, we thought we had arrived at another, more appropriate title, i.e. 'The General Practitioner Group'; however, we were eventually billed, to my chagrin, as 'The Psychiatric Group'. At this stage we gave up. At least if nobody else seemed to appreciate our purpose we, in the seminar, felt that we shared a common ideal.

b) Tape Recorder Incident

Research work has shown that recall of group meetings is very fallible, and quite significant incidents are often forgotten and possibly repressed by the leaders. Having a poor memory I decided to tape-record the seminar to facilitate my own thoughts about the group afterwards. Unfortunately, I did not take a tape-recorder to the first meeting, but brought one along to the second meeting and left it on a side table, and discussed recording the seminar with the members who were already in the room. As luck would have it, there were two latecomers, one of whom had had previous experience of seminars.

Without any disrespect to other members of the seminar, she was the most experienced member in psychodynamics. When this individual noticed the tape-recorder, paranoia became rampant, and there was a heated, irrational discussion. I eventually capitulated and said that I would not record the seminar. This was my first serious mistake - she had made a successful bid for leadership of the seminar, and was colluded with in this by the rest of the participants. I was shown up by this event as having clay feet, and this, allied to my youthful appearance had, I feel delayed the development of the seminar for a considerable period of time.

c) Attempt to Become a Therapeutic Group

Michael Balint has described in his writings the drive which was shown on many occasions in his seminars to turn them into therapy sessions. Although I had an intellectual appreciation of this, I did not anticipate that this impulse could be so

strong. On several occasions in the first trimester members expressed a wish to discuss some of their personal difficulties, and was met with great hostility by the other members of the group when I forcibly intervened and stated that this was not one of the aims of the group. I had to reiterate on a number of occasions that we were going to discuss cases in the group, and this was our only function.

Dr Skinner, in one of our private conversations, spoke about the function of a referee. If he is to function effectively he must stamp his personality on the game in the first few minutes. This principle applies also in a group situation. The leader and the participants must establish the norms of the group in its early phase. In dealing with the tape-recorder incident I failed to be sufficiently positive, but in stating the manner in which the group was to function I was quite adamant. Often we seem to become so preoccupied with internal reality that we do not deal sufficiently firmly with external reality when it intrudes, and there are some situations where one has to put one's foot down.

d) Visit of Dr M J Courtney

Most groups have a natural evolution. The initial phase is one of questioning and establishment of group norms. However, this is followed by a period of unquestioning belief in the omnipotence of the group's experience and existence. This is a period of unbounded optimism, when all problems are going to be solved by the magic of ‘groupness’. Inevitably reality reasserts itself after a varying period of time, and there is a decline in group morale, with loss of confidence us the group itself and in the leader. There is a great deal of questioning as to whether the group is of any use, and the group itself is pervaded by a lack of direction and hopelessness. This period characterised the third term of our group, and it was interesting that at this time when the group had lost confidence in me as a leader, an invitation was extended to Dr Courtney to come to visit us. His visit happened to coincide with the last meeting of the first year of our group.

The meeting itself was memorable for the activity of the group. They were more animated than I had seen them for many months, and were on their best behaviour in order to show our visitor how much they had gained from the group experience. He gave his 'apostolic benediction' to us, saying that he had felt very much at home, and that we seemed to be following Michael Balint's principles to the letter. There was a post-group rendezvous at the home of one of the members, and the evening could only be described as manic. Great optimism for the future of the group was expressed, and we all went off on summer holidays with the feeling that confidence in the group itself had been restored.

e) The Case Material

I was unprepared for the sort of material that members brought to the group; I had expected we would discuss ordinary, everyday exchanges in the surgery. However, with monotonous regularity, case after case with severe personality disturbance was produced. Readers will be aware of the YAVIS type of patient, i.e., the young, attractive, verbal, intelligent, and successful patient. If you have to select a patient for psychotherapy the nearer you approach that ideal the more successful will be the outcome. All the cases I heard about seemed to be non-YAVIS and conformed more to the stereotype of the patient that a skilled psychotherapist would have difficulty in managing.

I am a great believer in the principle of preserving oneself, as it is only in this way that one can be of benefit to other people. Attempting to take on too many insuperable problems would tax the already strained timetables of general practitioners, even if it did not strain them emotionally.

f) Group Identity

The group has, as expected, developed its own form of communication and culture over a period of time. Initially we seemed such a heterogeneous group and it was difficult to see how we would ever get to know each other. We have now shared many experiences, and it is noticeable when we get together that one stimulus word

or phrase will unleash a variety of emotions and recollections. In a relatively short period of time we became very cohesive and the group bond is now so firm that the original seven members of the group are here tonight!

Summary

In conclusion I would like to say that I have found this a personally maturing and very rewarding experience. It has emphasised for me the difference between community and hospital practice. I have been frequently amazed at the difficult type of patient that the general practitioner has had to continue seeing, as he cannot pass the buck! I feel that this type of seminar helps enormously in understanding and tolerating the emotional demands which are made in the doctor/patient relationship. I hope we have achieved that in Nottingham, but only time will tell.