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## **The Role of the Balint Group Leader: A Critical Re-appraisal (1986)**

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My re-appraisal consists solely in relation to general practitioner Balint-group leaders, as I still believe that the primary model of the Balint-group leader is of a psychoanalyst who understands the general practice setting. Our problem as general practitioner Balint-group leaders is that we, broadly speaking, are not psychoanalysts and are too deeply identified in the general practice setting, in which we do our daily work. Although we are not psychoanalysts, we must have absorbed, perhaps by a process of psychological osmosis, something of the analyst's understanding of unconscious processes. Without a training analysis and the supervision of cases in that discipline, it is difficult to validate the general practitioner leader's qualifications to be a Balint-group leader. I certainly could not validate my own credentials. I have been encouraged by Enid and my dear late friend and colleague Mary Hare, to accept that I have some understanding of unconscious processes as revealed in group-work, although I often remain sceptical myself.

The Society is honouring me in asking me to give this talk, and I have been touched by some personal apologies from members who cannot be here tonight. It is perhaps these mundane events that make me reflect on an interesting parallel. Many of you are apparently approaching this evening with the unrealistic and idealised expectations that the Old Guard (of which I am not in historical terms a member, though they often seem to forget it) approached Michael and Enid in that first seminal seminar.

We somehow expected the Balints to tell us the answers to those questions we raised about our work, even though we knew they were not general

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practitioners. In your sober moments you know perfectly well that given your long experience of working in Balint-groups with many leaders that I am not in a position to tell you anything you do not know already, and that my best hope is to shine a light on our work from a slightly different angle so that you will be able to say 'Of course I know that!' And of course you do.

It is in the preparation of this talk that I have perceived in one of the great Balint exhortations, 'Have the courage of your own stupidity', a deeper level of truth. I am courageous, sitting here in front of you, not because I know more than you, understand better than you, or lead a group more competently than you, but because I understand the word stupidity more deeply. I know I am stupid, but the Balints have allowed me to come to terms with it — I understand more about myself as a doctor (and as a person come to that), and have learned to live with it better. In Enid's words it concerns the naturalness of man himself, particularly the aspects which seem most irrational and unacceptable.

You are now, I hope, fully prepared for that sense of anticlimax which is bound to descend on you as the evening advances. Jack Norell posed the question to the Leaders' Workshop 'What is the essential role of the group-leader?' My reply would be 'the encouragement of a "safe" atmosphere for the doctors to explore their own personalities interacting with their patients, so that they may become more flexible and develop new skills in dealing with patients as people in distress! That's a tall order, and it obviously needs putting into Anglo-Saxon. Perhaps, in simpler terms one might see the leader's role as freeing the imagination of the members of the group, with the hope of reducing any rigidity in them, while at the same time protecting them from personal overexposure. The leader must not be too authoritarian, but always responsible for what goes on in the group. He may be wise to eschew

psychological obita dicta, but on the other hand a short burst of 'teaching' may be entirely appropriate. This does not mean that he has to expound any theory, but boldly say what has to be said if he feels the group is going down the wrong path; calling every patient 'manipulative' for instance.

The introduction of such jargon, especially if pejorative, can easily become a canker. The problem is that, especially with a new group, there is a great pressure on the leader to 'succeed', whatever that might mean. Principally it may mean that the group should not fall apart or leave. This tends to promote too much activity on the leader's part, 'trying too hard' in fact, and we all know what that does for our tennis shots! If one looks on the continued life and growth of a group in the same way as one might approach a patient seeking self-understanding and personal growth, it becomes obvious that the leader must aim at an active passivity, tuning his third ear to all that goes on in the group, whether it be the kind of case presented, the reaction of the members to the case material, the presenting doctor, and each other. For instance, is there a resonance between the patient's problems presented and the doctor's own? Do certain members always behave in a particular way, and what does that mean?

A problem which may persist for the leader is the temptation to treat the presented patient, rather than lead the group. This is a bunker which seems difficult to get out of. I have observed it often in the Leaders' Workshop, and even by experienced analyst Balint-group leaders commenting on demonstration groups at International Congresses. The problem is that the leader must make a diagnosis of the presented patient quickly and privately, and then use this in terms of the group-work only. That doesn't mean the leader will understand the case perfectly, and may often miss aspects which group members discern, but that is how it should be. However, it does allow

the leader to formulate what he would like the group to learn from the presentation of the case.

But apart from listening to all that goes on, the leader must also listen to what is not said. Such negative findings can be as, or more important, as what is actually said.

With regard to the interaction of the group, there must be a constant watch on any vicious tendencies which may arise, and need to be countered, and the difficult line between constructive confrontation and open aggression must be drawn and held.

Even group interpretations may occasionally be useful, though their use should probably be sparing if avoidance of a therapeutic group is to be achieved. Other questions are thrown up: What should govern the nature and frequency of the leader's remarks; by what criteria may a leader judge his/her effectiveness at the end of a meeting (or in previous meetings)? But these expose the problem, such judgements can only be retrospective and applied to a particular group session or series of sessions. Making plans in a vacuum is a meaningless exercise.

But this is all old hat, and rather than listening to me developing this in detail, I should like to try a participatory exercise, to see if it is a useful analytical exercise (using analysis in the vernacular sense). I have asked the members of the Leaders' Workshop to bring a case, and I am now going to invite them to come into the centre in two interlocking circles: the inner one representing group members, and the outer one, leaders. I am going to hand them each a little folded card, inside which is written an 'instruction', if they will bear with me using that word. The presenting doctor will be presenting a genuine case, but all the other members of the group will be behaving in a manner distorted by my instructions. Each of the leaders will have received

instructions which request him/her to concentrate on one particular dimension of the leadership role. I shall attempt to act as master of ceremonies, and we can arrest the process to discuss anything that arises, or wait until some time has elapsed in the group-work and discuss the various points which have arisen. So, let's try it.

The members of Leaders' Workshop present were invited to sit in the inner ring of a fishbowl arrangement. They were then handed small cards, alternately to a doctor who would be a groupee (presenting group-member), and a leader, so that in effect the group was made up of nine groupees and eight (part-time) leaders with the author as master of ceremonies.

What was written on the cards appears in the Appendix. The first case discussion (at a time when nobody in the inner circle knew what was written on the cards other than the one held in the doctor's hand (and all totally unknown to the outer circle), proceeded remarkably similar to a real Balint-group discussion. The author cut it short after half an hour, and invited each doctor to read what had been on the card.

A further set of cards was then handed round the inner circle, the previous groupees becoming leaders and vice versa. This time the discussion was stilted and unreal, the reason for this being disputed. Was it that the groupees did not believe the case to be an actual one, or was it that everyone knew what sort of role instructions were printed on the cards? The author contended that the exercise demonstrated that one couldn't lead a group by numbers.

In fact, in the first case the master of ceremonies did not speak. In the second case he made one attempt at a group interpretation (that being his role listed on the card). There was an extremely lively discussion, in which all points of view were advanced, but there was only general agreement that it

did attempt to tease out various facets of groupee behavior and leadership activity. It was thought that this aspect might usefully be explored in greater detail at another meeting.

It was thought that the 'game' would have been improved if there had been only two people playing leader roles, as it was clear that the groupees could not focus on any specific leadership because of the fragmentation of the leader role into nine separate individuals.

## **Appendix**

### **Groupee Cards**

- 1) You are a groupee (not a leader).  
If you have a case — Yes, you have! Claim priority. If you haven't thought of a case before tonight, pick the nearest 'pregnant nun' and present it as if you are a crazy doctor (in a controlled sort of way).
- 2) You are a groupee (not a leader).  
Please present a case if you want (allowing for the usual bargaining).  
During the discussion of the case comment on any traditional aspects (medically speaking) that you can identify, to the exclusion of the emotional.
- 3) You are a groupee (not a leader).  
If you have a case, please present it (allowing for the usual bargaining).  
If you are not selected, please support the presenting doctor in any way you like during the discussion of the case.
- 4) You are a groupee (not a leader).  
If you want to produce a case, do so (allowing for the usual bargaining).

If you have not a case, or are not selected, please be somewhat aggressive towards the presenting doctor during the discussion.

- 5) You are a groupee (not a leader).

If you have a case, present it (allowing for the usual bargaining).

Whether or not you present, please challenge the leader's 'hidden agenda' during discussion.

- 6) You are a groupee (not a leader).

Even if you have a case, please do not offer it, and do not join in the discussion of the case.

What a dreadful task I have set you! Bear with me if possible! And remember how you felt for later.

- 7) You are a groupee (not a leader).

If you wish to present a case, do so (allowing for the usual bargaining).

If you have not a case, or are not selected, please contrive to have a conversation with the person next to you, regardless of the group work.

- 8) You are a groupee (not a leader).

If you want to present a case, do so (allowing for the usual bargaining).

If you have not a case, or are not selected, try and get the leader to tell the group the 'answer' to the presenting doctor's problem during the discussion.

- 9) You are a groupee (not a leader).

Even if you have a case, please do NOT present it. During the discussion please play the role of a 'superior' doctor who knows exactly what to do about the case presented, and tell the group what!

For the second case card No. I read:

1) You are a groupee (not a leader).

If you have a case — Yes, you have! Claim priority. If you have not thought of a case before tonight pick the most goddam awful case you are dealing with at present, and present it in distress.