

Some Common Forms of Resistance to Balint Activity

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It's one o'clock, time for Balint group in the family practice residency program. The Balint group leaders, the behavioral scientist and the family physician, are in the gathering place, awaiting the arrival of the residents. Time passes. One resident comes in, saying two others will be late because they are running over in clinic. Another comes, saying he has to leave early to get to his next rotation on time, which is half an hour drive away. A third arrives (it is now 1:15), and is almost immediately paged. By 1:30 four residents are there, a reasonable quorum. But there are several chronic non-attenders, despite the faculty's ostensible support for this activity. The faculty are frustrated, but not sure what to do about it. A case is presented, but there is only half an hour for the interesting discussion which ensues, and under this pressure a certain problem-solving atmosphere is evident.

What is happening here? There are certainly reality considerations which can make attendance logistically difficult. And problem-solving discussions, particularly in a training program, can be helpful. But psychoanalysts have another answer as well: resistance. The phenomenon of resistance is a central tenet of psychoanalytic theory, and is part of what makes Balint work a long-term endeavor. As Michael Balint has noted, "To be able to make a true comment on an involved doctor-patient relation 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." (italics added)

Medical anthropologist Howard Stein defines resistance as simply "an unconscious barrier to learning about our patients and ourselves." In other words, the opportunity for insightful scrutiny of our interactions with patients, in the company of others, can be threatening as well as hopeful, and this threat and the feelings it engenders are unconscious. Unconscious feelings tend to be acted out rather than observed; hence the non-attender or the unproductive discussion. As Enid Balint, Michael Courtenay et al have noted in their recent book, The Doctor, the Patient, and the Group, "doctors have defences just like everyone else, perhaps more so on account of the nature of their work." Physicians need defenses in order to deal with patients, and also in order to deal with groups where their relationships with patients are discussed!

Although the hope of being understood by someone who cares is powerful, such understanding is most often resolutely resisted as well as collaborated with. The early analyst Ferenczi alluded to the core of resistance in the succinct title of his 1926 paper, "The Problem of the Acceptance of Unpleasant Ideas." Balint work, in its aim of a limited personality change in the doctor, may unconsciously be seen by participants as threatening to tear down defenses. This dismantling, whether feared or real, may be seen as more uncomfortable than the doctor's current hard-won mode of operating with his/her patients. Masud Khan puts it this way: ". . .we humans are, at root, fearful, even of that which extends us. Hence we live hidden and divided within, sharing a little with the other, now and then, but largely holding back." In an interview Lucy Candib did with Gayle Stephens, Dr. Stephens quotes Michael Balint as having said to one of his groups, "you know, you don't lack the time, you don't lack the skills--what

you really lack is the nerve, the heart, to want to have this kind of intimacy with your patients." Some of the defenses we all have against emotional involvement with patients also appear in our reluctance to deeply involve ourselves with Balint work.

Here is how the unconscious resistance may feel to the individual members of the Balint group: the doctor wants to get help from his/her teachers and colleagues, but it is strange and frightening; the doctor wants to cooperate and present cases in a free-floating way without notes, but this may cause humiliation, shame, or embarrassment; the doctor wants understanding from the group, but obtaining it may be dangerous, uncertain and costly. The kinds of defenses we all have thus come into play in group attendance and in group process, as well as in all human interactions. And mostly these resistances are against insight. Analyst Leo Rangell puts it this way, "resistances occur in life situations as well as in therapy. These can occur whenever insight comes or threatens to come from any direction below the level of a defense, from a teacher, an adversary, a chance encounter, or a friend." These basic resistances are countered in Balint work by the support of the group process. Michael Balint described this process: "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 . . . on the contrary, he feels that he has helped the group to progress, using his failings as stepping stones."

The words defense and resistance are sometimes used interchangeably, with the word defense being used more about life situations, and resistance for therapeutic situations. Anthropologist George Devereux points out an example of defense in a life situation in the old joke: a man's wife says to him, "if one of us dies, I'm going to move to Los Angeles." The man can respond to the logical content of this statement, and point out to her that, actually, either one of them might die. In which case he may be resisting knowledge of the underlying message, which is in all likelihood, "I hope you die, so that I can move to Los Angeles." Balint group leaders would be well advised to pay attention to the underlying unconscious content of certain communications as well as to the rational, conscious content.

How do resistances appear within the context of Balint activity, other than poor attendance or non-attendance? First, in the descriptions of interactions with patients during case presentations. Oliver Samuel, in a 1989 article about how doctors learn in a Balint group, summarized some of what he called defensive reactions shown by group members. Many of these may seem familiar to Balint group leaders: being cheerful and optimistic despite appalling difficulties; not trying to understand the patient; being gratified by the patient's dependency; being supremely self-confident of the doctor's own ability to solve the patient's agony; being contemptuous or making fun of the patient's difficulties; being completely overwhelmed and hopeless about the patient. Many of these resistances may result in simplistic discussion: In the words of psychoanalyst Roy Schafer: "not ever looking at things more than one way is easily the most powerful `resistance' of all." Balint work is complex and challenging for all participants. The discussion is free-floating and open-ended as opposed to the usual medical goal-directedness and problem solving. Balint groups certainly challenge us

to look at things in more than one way. If the group is tending toward a one-sided view of a particular physician-patient interaction, the leader might suspect these kinds of defenses are operating, and might encourage the group to move in the direction of more complexity.

The well-known trio of group behaviors observed by Wilfred Bion has greatly influenced Tavistock Balint leaders in London, and is in fact a trio of resistance. These are: (1) the tendency for the presenting physician to pair with the group leader and secure his attention for himself, (2) the tendency for group members to depend on the leader for the magic answer to the dilemma presented in the case, and (3) the tendency of group members to flee at times from difficult aspects of a case by shifting attention to other matters. Bion felt that the task of the group leader was simply to notice such group behavior. Enid Balint has suggested a certain set of stages in the life cycle of a Balint group, and these kinds of resistances may appear particularly in her two early phases: (1) over-idealization, in which admiration and imitation of the leader take place, and (2) compliance and rebellion, in which these two false solutions are alternately adopted in response to the group's ideas.

How should the Balint group leader deal with resistance? This is a complex question. Some answers are: respectfully, subtly, and cautiously. For starters, the way in which Balint work is presented to potential group members is important, for this may dispel some very early unconscious fears and misleading fantasies about the nature of the work. Recent issues of the American Balint Society Newsletter have addressed the issue of presenting Balint work to the uninitiated. As Michael Courtenay has said, "Young doctors today seem either unaware that Balint-work is still alive, or frightened by their perception of it as something very esoteric."

The group leader needs to balance the members' understandable need for defenses against their wish for emotional growth which led to their participation in the first place. It is incumbent upon group leaders to recognize their own defensive tendencies, not to get too judgmental or try to ride rough-shod over resistances from group members. Since Balint groups are not therapy groups, only the briefest interpretations about resistance are in order, and only when the resistance is clearly disrupting or making impossible the work of the group. An awareness by the group leader of the various levels of rigidity or flexibility in each group member is important over time. The group leader then needs to be able to hold the group's or the individual's distress, with the faith that Balint work takes a long time, that the time will be available, and that even the most powerful resistances can soften with the caring, understanding, and support of the group.

Tom Main, in his 1978 Balint Memorial lecture entitled "Some Medical Defences Against Involvement with Patients" said a great deal about resistance very eloquently. Main said: "The strains of trying to understand the distress of people rather than merely objectively observing pain in various conditions can be immense; yet it is only by subjectivity with all its strains that we can experience our own lives and joys and pains, and the joys or pains and the livingness of others, and thus begin the task of understanding people and their troubles."

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