‘The Drug “Doctor”’: Michael Balint and the Revival of General Practice in Postwar Britain

In the early 1950s, the Hungarian psychoanalyst Michael Balint, still a newcomer in London, was asked by Enid Eicholtz, a caseworker and the first secretary of the Family Discussion Bureau (FDB), to help her at the Bureau.[1] Eicholtz became interested in psychotherapy and psychoanalysis while working with dislocated families that she helped find a new home. However, she noticed that these people were mainly interested in talking about ‘their personal experiences and relationships’ rather than in finding new accommodations. Her conclusion was that ‘behind many practical problems were relationship problems – more specifically marital problems – and that these were surprisingly difficult to resolve’.[2] Eicholtz then decided to train in psychoanalysis. She was supervised by the senior psychoanalyst John Rickman. Her engagement with him and other psychoanalysts enabled her to make connections also with Tavistock psychiatrists, some of whom, like John Bowlby and Henry Dicks, helped her establish the FDB. It was there that she met Balint, who very soon became not only her professional partner but also her husband.

The two co-designed a psychoanalytically informed training for family counsellors which showed them how analysing the relationship between couples and their counsellors can reveal crucial elements in the problematic relationship between the partners themselves. This new approach to counsellor training (which Balint called research-cum-training), led Enid to establish a new innovative peer group, this time for general practitioners (GPs). Their goal was to create a group where GPs would discuss case studies of a psychosocial nature with their peers.

[1] See Michael Balint, Enid Eicholz, and others, ‘Report on the Conference Held by the Family Discussion Bureaux in September 1950’, Enid & Michael Balint Papers, The Albert Sloman Library at the University of Essex (Box 17). The FDB later was known as the Tavistock Institute of Marital Studies. On the Family Discussion Bureaux and the emergence of postwar state-supported marriage welfare services see, Teri Chettiar, ‘“More than a Contract”: The Emergence of a State-Supported Marriage Welfare Service and the Politics of Emotional Life in Post-1945 Britain’, *Journal of British Studies*, 55:3, 2016, pp 566-591. For the history of the Tavistock Clinic see Henry V. Dicks, *Fifty years of the Tavistock Clinic*, London: Routledge & Kegan Paul, 1970; Peter Miller and Nikolas Rose, ‘The Tavistock Programme: The Government of Subjectivity and Social Life’, *Sociology* ,22:2, pp. 171 - 192

[2] Ibid., pp., 576-7

In 1957 Balint published his seminal book *The Doctor, His Patient and the Illness*, [3] in which he discussed the story of his work with the doctors and provided a model for the emergence of Balint Groups around the world. In the second half of the 1950s, many British GPs read this book and wanted to become part of this new movement. Many of the leaders of the Royal College of General Practitioners between the 1960s and 1990s were graduates of Balint Groups; some of them, like Max Clyne and John Horder, were members of the original group.[4] In the late 1950s, Michael and Enid Balint were appointed professors at the University of Cincinnati and regularly spent time there. Balint became a popular speaker not only in Britain but also around the world. What started as a small peer group of GPs at the Tavistock Clinic became, by the 1960s, a worldwide medical movement which still exists today.[5]

In this article, I raise several questions about the motivations behind the founding of this movement in Britain, arriving as it did only a few years after the establishment of the National Health Service (NHS). Why was Balint's new approach so appealing to a new generation of British doctors after the Second World War? What were the social and cultural conditions in the early 1950s that made psychoanalytical ideas relevant to British GPs, who were not very interested in psychoanalysis? And finally, what can we learn from this experiment about new notions of public health as a major aspect of citizenship in the new age of the British welfare state?

The first part of the article locates the Balint movement in the context of the emergence of a 'psychosocial' discourse in the interwar period, which emphasised the influence of the social environment and group psychology on the individual. This new way of thinking

[3] Michael Balint, *The Doctor, His Patient and the Illness*, London, 1957.

[4] See Rhodri Hayward, *The Transformation of the Psyche in British Primary Care, 1870-1970*, London, 2014, pp. 91-115; John Horder, 'The First Balint Group', *British Journal of General Practice*, 51:473, 2001, pp. 1038-39.

[5] For an overview of Balint Groups in the 1950s and 1960s, see the two chapters by Robert Gosling in Harold Stewart, *Michael Balint: Object Relations Pure and Applied*, London, 1996, pp. 88-110. Gosling was also Balint's assistant for a few years. See also Thomas Osborne 'Mobilizing Psychoanalysis: Michael Balint and the General Practitioners', *Social Studies of Science* 23:1, 1993, pp. 175-200. For a more contemporary history of the Balint movement worldwide see, John Salinsky, 'The Balint Movement Worldwide: Present State and Future Outlook: A Brief History of Balint Around the World', *American Journal of Psychoanalysis*, 62:4, 2002, pp. 327-335. While there is recently a renewal of interest among scholars in Michael Balint's work, a substantial research on Enid Balint's life and work is yet to be done. See, however, Jonathan Sklar, 'Regression and New Beginnings: Michael, Alice and Enid Balint and the Circulation of Ideas', *International Journal of Psycho-Analysis*, 93:4, 2012, 1017-1034.

replaced an older paradigm, one which perceived medicine as dealing mainly with physiology. Group therapy developed during and after the war, mainly within the Tavistock Clinic. The second part of this study concentrates on a hitherto unexplored source: the minutes of a small discussion group, founded in April 1951 and led by Michael Balint and the senior Tavistock psychiatrist Henry Dicks, for discussing the role of psychology in general practice. It was there that GPs revealed many of the then-problematic dimensions of their work under the new NHS, as well as their new needs as family doctors in the postwar era. The decision to establish the first Balint Group was taken during these meetings.[6] The minutes of this group allow a deeper investigation of the social and cultural history of the Balint movement in postwar Britain, and will answer some of the questions about the motivations for its foundation.[7] The history of the Balint groups raise some social and cultural questions that go far beyond the history of medicine into the cultural history of postwar Britain. From this material, I show how the GP is reimagined not only as a physician but also as a sort of a psychotherapist, social worker, and moral authority in the postwar decades.

Changing paradigms: the emergence of the 'psychosocial' in British medicine

The 'psychosocial' became a key notion in wider parts of interwar medicine.[8] A new generation of psychologists, psychiatrists, psychoanalysts, social theorists, and policy makers made a major effort to detach themselves from biological approaches, which had been dominant in Britain since the second half of the nineteenth century. The new approach concentrated on the social factor as the most important one in the functioning of the human body and mind. It is not only that social factors were now perceived as the key to the

[6] For the decision to establish a regular seminar for discussing GP case studies, i.e. the first Balint Group, see Henry Dicks to Balint, 2 July 1951, Balint Papers, Geneva Archives (hereafter GEN. The Balint Archives were recently transferred to the Archives of the British Psychoanalytical Society, London, where they have not been catalogued by the time of submission of this article).

[7] See: Tenth Session of GPs Discussion Group, 21 June 1951, GEN. This last meeting of the 'pre-Balint Seminar' shows that the demand for the Group, and some suggestions as to its form, came from the doctors and not from Balint.

[8] Rhodri Hayward, 'The Invention of the Psychosocial: An introduction', *History of the Human Sciences*, 25:5 2012, 3-12.

psychological wellbeing of the individual, but also that 'the conflation of mind and society promoted an implicit hierarchy in which the social took priority over the biological'.[9]

One product of this 'psychosocial' discourse was the emergence of 'social medicine' as a new discipline.[10] David Armstrong points out that this new field of study 'incorporated preventive medicine, public health, and a focus on social relationship'.[11] The founders of social medicine aimed explicitly to politicize the medical domain, arguing that the state is not only obliged to provide its citizens with a decent standard of public health, but also to take into account in its medical and social policies the mutual influences of medicine and social factors such as the economy, education, and urban planning.[12] As Dorothy Porter argues, 'debates surrounding social medicine in the interwar years intersected with the debates surrounding the planning of a national health service, and the establishment of access to services free at the point of delivery as a fundamental social right of democratic citizenship'.[13]

This new attention to the wider implications of a healthy psychosocial environment also created the right conditions for certain influential changes in postwar psychiatry.[14] First,

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[9] Ibid., p. 6.

[10] See Dorothy Porter, 'Changing Disciplines: John Ryle and the Making of Social Medicine in Britain in the 1940s', *History of Science*, 30:2, 1992, 137-64; Porter, 'From Social Structure to Social Behaviour in Britain after the Second World War', *Contemporary British History*, 16, 2002, 58-80; Jane Lewis, *What Price Community Medicine? The Philosophy, Practice and Politics of Public Health Since 1919* (Brighton, 1986), pp. 35-44; David Armstrong, *Political Anatomy of the Body: Medical Knowledge in Britain in the Twentieth Century*, Cambridge, 1983, pp. 38-41.

[11] Armstrong, p. 38.

[12] A major figure in implementing Social Medicine in the 1940s was Professor John Ryle, a notable physician, who became in 1942 the first director of the Institute of Social Medicine in Oxford. As Porter points out, 'he wanted to re-instate the sick-man, the whole person, at the centre of clinical practice and believed this required the study of man in disease and the human ecology of health' ('Changing Disciplines', p.147).

[13] Porter, 'From Social Structure', pp. 62-63.

[14] The influence of the new psychosocial way of thinking is demonstrated in the records of a big International Conference on Mental Health, which took place in 1948 in London. Its participants included leading psychoanalysts, psychiatrists and anthropologists such as Anna Freud, Melanie Klein, J.R. Rees and Margaret Mead. Many of the speakers emphasized the link between the mental health of individuals, families, groups, communities and states. For example, some speakers, such as John Bowlby, emphasized the role of good parenting and particularly good mothering as the basis for building strong families, and consequently creating good citizens. See Proceedings of the International Congress on Mental Health, ed. by J.C. Flugel, London, 1948. See also, Jonathan Toms 'Political dimensions of "the psychosocial": The 1948 International Congress on Mental Health and the mental hygiene movement', *History of the Human Sciences*, 25:5 (2012), 91-106; Daniel Pick, *The Pursuit of the Nazi Mind: Hitler, Hess, and the Analysts*, Oxford, 2012, Ch. 10. On the debate over 'Bowlbyism' in the postwar years see Denise Riley, *War in the Nursery: Theories of the Child and Mother*,

psychotherapy became a key form of treatment for different kinds of patients, including the more severe cases. In fact, this shift began during the war. At the beginning of the war, psychiatrists treating traumatized soldiers were still using some of the earlier methods used by First-World-War psychiatry, such as re-introduction to military life after a short period of rest, or re-education and persuasion in order to explain to soldiers the 'real' nature of their mental collapse.[15] These methods, however, appeared to be ineffective, and psychiatrists looked for different medical solutions. Alternative methods came from leading army psychiatrists such as Emanuel Miller, Wilfred Bion, and Lt Colonel J. D. W. Pearce, who before the war worked at (or were trained by) the Tavistock Clinic in London. The most influential among them was J. R. Rees, the director of the Tavistock, who was appointed, at the beginning of the war, as a consultant psychiatrist to the army at home and was responsible for much of the deployment of the psychodynamic approach in army psychiatry. Indeed, in the early 1940s, many psychiatrists adopted the new psychodynamically-oriented methods, and a lot of experimental work in this subject was done during the war. Perhaps most famous was the First Northfield Experiment in group therapy, which was carried out at Hollymoor Hospital in Northfield by Wilfrid Bion and John Rickman in 1942-43.[16]

Under the guidance of Bion and Rickman, a group of soldier patients was required to become a 'leaderless' therapeutic group.[17] The real aim was that the soldier patient would eventually overcome his initial resistance to this anti-authoritarian approach and take full

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London, 1983; and Mathew Thomson, *Lost Freedom: The Landscape of the Child and the British Post-War Settlement*, Oxford, 2013, pp. 79-105.

[15] See Edgar Jones, 'War and the Practice of Psychotherapy: The UK Experience 1939-1960', *Medical History*, 48:4 (2004), p. 496.

[16] On the Northfield Experiments see Tom Harrison, *Bion, Rickman, Foulkes and the Northfield Experiments: Advancing on a Different Front*, London, 2000; NafsikaThalassis, 'Soldiers in Psychiatric Therapy: The Case of Northfield Military Hospital 1942 –1946', *Social History of Medicine* 20:2, 351–368.

[17] This experiment was, in many respects, a complementary project to the Leaderless Group Test that Bion co-developed in 1942, that helped to establish the War Office Selection Boards (WOSBs), for improving the selection process of officers in the British army. The idea of the test was to ask a group of candidates to fulfil tasks, with no formal leadership, and then observe how individuals work for the success of the group as a unit. As Bion put it, the aim was to assess 'how any given man was reconciling his personal ambitions, hopes and fears with the requirements exacted by the group for its success' (Wilfred R. Bion, 'The Leaderless Group Project', *Bulletin of the Menninger Clinic*, 10:3, 1946, p. 78). On the collaboration of Tavistock psychiatrists and the army in the making of the WOSBs (including Bion's contributions) see, Alice Victoria White, *From the Science of Selection to Psychologising Civvy Street: The Tavistock Group, 1939-1948*, PhD Thesis, University of Kent, 2015. On the developing of the Leaderless Group Tests as a part of Bion's wider psychoanalytic and group theory and practice see Dorit Szykierski, 'The Northfield Experiment and the Enigma of Psychiatry without Psychiatrists: Exclusion by Inclusion of the Radical Contribution of W. R. Bion', *Organizational and Social Dynamics*, 8:1, 2008, pp. 38-62.

responsibility for managing his own hospital ward. In other words, Bion and Rickman hoped that this would become a 'therapeutic community' rather than 'group therapy'. However, it was in the Second Experiment, between spring 1944 to autumn 1945, that a more substantial attempt was made to create such a therapeutic community, this time led by S.H. Foulkes, Ronald Hargreaves, and Tom Main.[18] The latter kept his attempts to establish a democratic 'therapeutic community' at the Cassel Hospital, where he was a medical director from 1946. As Main explained many years later, the goal was to create a democratic community of patients who would run all aspects of their lives at the hospital. Main challenged the then authoritative model of hospitals, in which 'staff [were] to be only healthy, knowledgeable, kind, powerful and active, and patients to be only ill, suffering, ignorant, passive, obedient and grateful'.[19]

The clinical success of the Northfield Experiments – as well as their real influence on the flourishing of Group Therapy after the War – is still under debate among historians.[20] However, this argument generally overlooks the fact that group therapies became important not only for clinical reasons (justified or not), but also because of the postwar preoccupation with redefining what a 'group' actually is. In the postwar era, the need to explain why so many ordinary men and women in Europe became active – or passive – supporters of collectivist-totalitarian ideologies was one of the main reasons for 'the emergence of "the group" as a unit of study' in the 'psy' professions.[21] This emphasis on the 'group' is the context for understanding the success of Enid and Michael Balint's new model in their work

[18] For the history of the 'therapeutic community', see John Mills and Tom Harrison, 'John Rickman, Wilfred Ruprecht Bion, and the Origins of the Therapeutic Community', *History of Psychology*, 10:1, 2007, 22-43.

[19] Tom Main, 'Some Psychodynamics of Large Groups', *The Ailment and other Psychoanalytic Essays, London*, 1989, p.103. On Main and the Cassel Hospital see, Teri Chettiar, 'Democratizing Mental Health: Motherhood, Therapeutic Community and the Emergence of the Psychiatric Family at the Cassel Hospital in Post-Second World War Britain', *History of the Human Sciences*, 25:5, 2012, 107-122.

[20] See, for instance, Pearl H.M. King, 'Activities of British Psychoanalysts During the Second World War and the Influence of their Inter-Disciplinary Collaboration on the Development of Psychoanalysis in Great Britain', International Review of Psychoanalysis, 16 (1989), pp. 15-32, Jones, 'War and the Practice of Psychotherapy' Nafsika Thalassis, Soldiers in Psychiatric Therapy: The Case of Northfield Military Hospital 1942–1946', *Social History of Medicine* 20:2 (2007), pp. 351–368; Szykierski, 'The Northfield Experiment and the Enigma of Psychiatry without Psychiatrists'; Lawrence J. Brown, Rickman, Bion, and the clinical applications of field theory', *International Forum of Psychoanalysis* 20:2 (2011), pp. 89-92; Pick, *The Pursuit of the Nazi Mind* 198-9, . The popularity of Group Therapy and Group Dynamics in the British 'psy' disciplines, and especially in the Tavistock circles, is well demonstrated in E. L. Trist and Hugh Murray (eds), *The Social Engagement of Social Science: A Tavistock Anthology*, London, 1990. This collection exemplifies how widely defined the concept of the 'group' was. Indeed, it could include anything from, to POWs, and the nation itself.

with GPs. But before turning to discuss their Balint Group, a few historical remarks on general practice before and after the war are necessary.

General practice in the postwar era

The National Insurance Act of 1911 provided, for the first time in British history, a scheme for a National Health Insurance (NHI), although its aim was to cover only the working population, which included low-income men and single working women, as well as few waged worker married women. However, except from paying maternity leave, the NHI scheme did not cover either the wives of working men or their children. A full coverage for all women and children was introduced only with the new NHS in 1948.[22] The other radical change in British public health under the new NHS was the nationalization of all hospitals and the centralization of many services around teaching hospitals.[23]

The changes in general practice were more minor. The NHI introduced a new 'panel' system, with the outcome of GPs' income being greatly increased in the interwar period.[24] Therefore, doctors aimed to preserve the financial benefits of their profession, and in the years before the foundation of the NHS, the British Medical Association (BMA) successfully fought to preserve general practice as a 'liberal' occupation. Thus, under the NHS, GPs remained independent professionals (i.e., not salaried by the state, as initially planned by the NHS more radical architects in the early 1940s). Thus, the only major change that the NHS created in general practice was the unexpected rapid movement of middle-class private

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[21] Pick, *The Pursuit of the Nazi Mind,* pp. 190-99. Tom Main, for example, thought that there are strong affinities between some forms of psychiatric hospitalization and the creation of psychosocial conditions for totalitarian regimes. See, Chettiar, p. 119.

[22] See, Anne Digby, 'Poverty, health and the politics of gender in Britain, 1870-1948', in Anne Digby and John Stewart (eds), *Gender, Health and Welfare*, (London, 1996), p. 75.

[23] On the founding of the NHS and its differences from the NHI, see Anne Digby, 'Continuity or Change in 1948? The Significance of the NHS', in Karen Bloor (ed), *Realism and Reality in the National Health Service: Fifty Years and More*, (York, 1998), pp. 4-17.

[24] A 'panel doctor' was a GP who was registered to accept patients under the NHI and later the NHS schemes. On the increasing of GPs' outcome see Anne Digby and Nick Bosanquet, 'Doctors and Patients in an Era of National Health Insurance and Private Practice, 1913-1938', *The Economic History Review*, 41:1, 1988, pp. 74–94. Most GPs, however, mixed private and 'panel' practice in a way that created the possibility for class discrimination to be 'formally built into the provision of medical treatment' (p. 82).

patients to the new free service. Within a few years, only a few GPs remained 'all-private'.[25] However, preserving their independence neither helped them much in improving their professional authority, nor in developing the quality of the care they provided: they remained the 'Cinderella service of the early NHS'.[26]

The new scheme evoked strong feelings of injustice among GPs, mainly of the older generation (indeed, many old doctors took early retirement). There were also objective reasons for the fact that general practice was considered a 'Cinderella service', particularly after 1948. The state not only invested vast amounts of money in the newly nationalized hospitals – and thus greatly increased the number of hospital consultants – but also demanded an increasing professionalization of the service. Many of the medical problems that were traditionally treated by GPs now became the task of an expert.

In 1950, the Australian-born practitioner J.S. Collings published a notable Report (funded by the Nuffield Trust) in the *Lancet* on the professional state of general practice in England.[27] This Report, according to some scholars, marked an important shift in the history of general practice in Britain.[28] It was an indictment of the British state for utterly neglecting general practice. The report revealed that the medical quality of general practice was deteriorating and the working conditions in practices (particularly in industrial areas) posed a real danger to the public. Moreover, Collings argued, as long as general practice did not become a first priority for the state, there was no chance of real improvement in other medical services (including, for example, the level of hospitals, which were already prioritized by the state). Collings writes:

> My observations have led me to write what is indeed a condemnation of general practice in its present form; but they have also led me to recognise the

[25] Digby, 'Continuity or Change in 1948? The Significance of the NHS', p. 9. Discussing the 'before' and 'after' of the NHS in one of the first meetings of the Balint Group, one doctor said: 'working classes are OK. It is the middle classes that are taking their revenge' ('Seminar on Psychological Problems in General Practice, 11 October 1951, p. 3, GEN).

[26] Ibid., p. 7.

[27] Joseph S. Collings, 'General Practice in England Today: A Reconnaissance', *Lancet* 255:6604, 1950, pp. 555–85.

[28] See Irvine Loudon and Mark Drury, 'Some Aspects of Clinical Care in General Practice', in Irvine Loudon, John Horder and Charles Webster (eds), *General Practice under the National Health Service, 1948–1997*, London, 1998, pp. 92-95; Roland Petchey, 'Collings Report on General Practice in England in 1950: Unrecognised, Pioneering Piece of British Social Research?', *British Medical Journal*, 311:6996, 1995), pp. 40-42.

> importance of general practice and the dangers of continuing to pretend that it is something which it is not. Instead of continuing a policy of compensating for its deficiencies, we should admit them honestly and try to correct them at their source.[29]

The Collings Report caused strong debate in medical circles. The British Medical Association dismissed the report and composed an alternative one, which aimed to refute Collings' findings completely.[30] But other researchers took on the challenge and conducted further research, for which the Collings Report served as a starting point.[31]

Not unrelated to the Collings Report, and equally important, was the establishment of the Royal College of General Practitioners in 1952. Not only did the new College create a major professional institute for training and research in general practice, it also designated the intention of a new generation of GPs to turn their profession into a medical discipline in its own right.[32] There was also a strong affinity between the College and the emergence of the Balint Movement. While, proportionally, only a small number of London-based doctors participated in Balint seminars between 1950 and 1970, many of them became leading figures at the College and in university departments of general practice. Their influence on the profession was nationwide.[33]

One should read the Collings Report, the establishment of the College, and the emergence of the Balint movement as belonging to the same psychosocial trend in British medicine after the Second World War. As some scholars have shown in the last two decades, the influence of figures such as Collings, Balint, and Stephen Taylor was much wider than general practice itself.[34] They were responsible for an epistemological shift in the understanding of the complex relationship between the doctor, the patient, and the illness. The psychosocial 'patient-centred' approach, which emerged

[29] Collings, p. 555.

[30] See Stephen J. Hadfield, 'A Field Survey of General Practice, 1951-2', *British Medical Journal*, 2:4838, 1953, pp. 683-706.

[31] See Stephen Taylor, *Good General Practice: A Report of a Survey* (London, 1954). See, Hayward, *The Transformation of the Psyche*, pp. 61-89, for Taylor's crucial role in shaping general practice as a psychosocial occupation after the Second World War. See, Hayward, *The Transformation of the Psyche*, pp. 61-89.

[32] Denis Pereira Gray, 'Postgraduate Training and Continuing Education', in *General Practice under the National Health Service, 1948–1997,* pp. 182-185.

[33] See Marshall Marinker, '"What is Wrong" and "How We Know It": Changing Concepts of Illness in General Practice', in *General Practice under the National Health Service, 1948–1997*, pp. 65-91, p. 73.

[34] See particularly Hayward, *The Transformation of the Psyche*; Marinker.

in the early 1950s, dominated the discipline of general practice for three decades, and was replaced only by new neo-liberal medical demands in the early 1980s.[35]

Budapest School in London

The son of a local physician, Michael Balint (Mihaly Bergsmann) was born in 1896 in Budapest to an orthodox Jewish family. [36] The Great War interrupted his medical studies, and he was sent to Russia and then to Italy. In 1915, he came back from the front and continued his studies, but he did not like medicine, which he considered 'uninteresting', and spent most of his time listening to lectures in many other subjects, such as mathematics, chemistry, electrical engineering, economy, and also psychoanalysis.[37] Alice Szekely-Kovacs – who would become his first wife – introduced him to Freud's 'Totem and Taboo' and 'Three Essays on the Theory of Sexuality', and then to the psychoanalytic world. In 1920, the two married, changed their name to Balint, and converted to the Unitarian Religion to avoid some of the sanctions imposed on Jews.

After Sandor Ferenczi's death in 1933, Balint became one of the leading figures in Hungarian psychoanalysis.[38] After the 1938 *Anschluss* in Austria, British psychoanalysts Ernest Jones and John Rickman helped the Balints to move to England. Just after their arrival, however, in 1939, Alice suddenly died. In 1948, after living several years in Manchester, Balint joined the Tavistock Clinic in London. During the 1950s and 1960s, he became one of Britain's leading psychoanalysts. In 1968, two years before he died, Balint was elected president of the British Psycho-Analytical Society.

In his work in Britain, Balint tried to apply many of the principles that had guided him and his colleagues in what was known as the interwar Budapest School. Recent literature has shown the pioneering role that this School played worldwide in making psychoanalysis an

[35] See Alex Mold, 'Making the Patient-Consumer in Margaret Thatcher's Britain', *Historical Journal*, 54:2, 2011, pp. 509-528.

[36] On Balint's life and work, see Michelle Moreau-Ricaud, 'Michael Balint: An introduction', *American Journal of Psychoanalysis*, 62:1, 2002, pp. 17–24; Harold Stewart, *Michael Balint: Object Relations Pure and Applied*; Judith Dupont, 'Michael Balint: Analysand, Pupil, Friend, and Successor to Sándor Ferenczi', in Lewis Aron and Adrienne Harris (eds), *The Legacy of Sándor Ferenczi*, Hillsdale, 1993, pp. 145-57; André E. Haynal, *The Technique at Issue: Controversies in Psychoanalysis, from Freud and Ferenczi to Michael Balint*, London, 1988, pp. 71-125.

[37] Bluma Swerdloff, 'An Interview with Michael Balint', *The American Journal of Psychoanalysis*, 62:4, 2002(1965), p. 384.

[38] Ibid., 393-94.

interdisciplinary profession, namely open to a wide range of practitioners, scholars, and public commentators.[39] For our purposes, the most relevant aspect of the Budapest School is the special attention that its leading figures gave to psychosomatic medicine and their attempts to integrate psychoanalysis with general medicine. Hungarian psychoanalysts persistently argued for the provision of psychoanalytic education to all family doctors.[40] Balint was indeed part of this effort to change the general standards of medicine according to new psychoanalytic criteria. In 1930, for example, he published a polemical critique of general practice in Hungary:

> The intimate relationship, which used to exist on a life-long basis between the patient and his doctor, has almost totally disappeared, replaced by quick superficial dealings. So, the basic flaw of the concept of the body as a collection of partial functions is more and more obvious. In the eye of doctors, the patient becomes an insensitive machine, a skilful combination of cleverly fitted parts; the totality of the person, a human being with his own goals and failures, his joys and sorrows, has practically vanished from their thinking.[41]

Restoring the holistic role of the GP as a family doctor was a vision that Balint outlined in 1930s Budapest, but came closer to fulfil only in his work with British GPs in the 1950s and 1960s.

Who needed the Balint Group?

Balint was not the first in Britain to promote the idea of providing GPs with psychotherapeutic skills. The therapist Eric Graham Howe had run a psychoanalytic course

[39] See Ferenc Erős, 'Some Social and Political Issues Related to Ferenczi and the Hungarian School', in Judit Szekacs-Weisz and Tom Keve (eds), *Ferenczi and His World: Rekindling the Spirit of the Budapest School*, London, 2012, pp. 39-54; Judit Mészáros, 'Sándor Ferenczi and the Budapest School of Psychoanalysis', *Psychoanalytic Perspectives*, 7:1,2010, pp. 69-89; Elisabeth Young-Bruehl, 'A visit to the Budapest School', *Psychoanalytic Study of the Child*, 57, 2002, pp. 411–32. Among the huge secondary literature on Ferenczi and his highly influential legacy see André E. Haynal, *The Technique at Issue: Controversies in Psychoanalysis, from Freud and Ferenczi to Michael Balint*, London, 1988; Adrienne Harris and Steven Kuchuck (ed), *The Legacy of Sandor Ferenczi: From Ghost to Ancestor*, New York, 2015; Peter L. Rudnytsky, Patrizia Giampieri-Deutsch and Antal Bokay (ed), *Ferenczi's Turn in Psychoanalysis*, New York, 1996; Judit Szekacs-Weisz, Tom Keve (ed), *Ferenczi for Our Time: Theory and Practice*, London, 2012; Júlia Gyimesi, 'Why 'spiritism'?', *The International Journal of Psychoanalysis*, 97:2, 2016, pp. 357–383.

[40] See, for instance, Franz Alexander, 'Discussion: Lay Analysis', *International Journal of Psycho-Analysis*, 8, 1927, p. 227-28.

[41] Michael Balint, 'The Crisis of Medical Practice', *American Journal of Psychoanalysis*, 62:1, 2002/1930, p. 13.

for GPs at the Tavistock in 1931. In 1935, the deputy superintendent at the Maudsley Hospital, Aubrey Lewis, suggested that GPs take on many of the medical functions that had previously only been assigned to psychiatrists. The *Lancet* and the *Practitioner* organized a pedagogic series on the psychiatric dimension in general practice. Similar views were expressed after 1948 by the influential GP Arthur Watts.[42]

Yet Balint Groups had a much greater influence on the British medical scene than previous experiments. Firstly, it was not a course or a training programme, but a 'group' governed by some of the principles of a 'leaderless group therapy'. This – as we have seen – was one of the most popular approaches in postwar British psychotherapy in general, and in Tavistock circles in particular. Moreover, in terms of research, it provided new findings that could not be obtained earlier. While Collings and others created 'anthropological' documents on British GPs, in the Balint Group the doctors were not passive subjects for an external observer.[43] In fact, they were rather participant-observers of their own profession, and thus helped general practice redefine itself when this was much needed.

In the spring of 1951, Balint and Henry Dicks co-organized a ten-meeting seminar with GPs. In these meetings, the two not only advised the doctors on the psychical perspectives of their clinical work, but also heard from them about their specific difficulties and challenges in treating psychosocial problems under the new NHS scheme. The group included 12 GPs, one psychiatrist, Balint, and Dicks. The initial topics for discussion requested by the doctors included questions about the right time to refer patients to psychiatrists; nervous children with anxious parents; sufficient knowledge of common psychological syndromes; how to maintain patients' physical treatment while they are undergoing a psychotherapeutic one; dealing with psychopaths; dealing with psychosomatic illnesses such as hysteria; discussing sex issues with patients; suggestion and hypnosis by GPs; impotence and frigidity; sleeping problems of patients; menopause; and adolescence.[44] All of these problems were discussed under the assumption that in these cases 'the most frequently prescribed drug is the doctor

[42] Hayward, *The Transformation of the Psyche*, pp. 52-59.

[43] While the participants of 1950s Balint Groups were London-based, enthusiastic young, and often, idealistic doctors – the observed GPs in the Collings Report came from regions other than London (industrial, urban-residential and rural areas in north and south England), and were more diverse in terms of age and background. See, Collings, 'General Practice in England Today', p. 555.

[44] 'GP Course', notes on requests for discussion, undated (although probably this note was taken after the first session Balint and Dicks held with the GPs).

himself but we have no pharmacology of this drug'.[45] Accordingly, the main Balintian question is what is the 'drug "doctor"', and how should we use it?

One of the first issues raised in the second meeting was the difficulty in giving patients injections. Dicks said that refusal to receive injections can be caused by the fact that 'doctors are often associated with attacking figures', and that for many people doctors have 'a double function[,] punitive and healing'.[46] This topic led the group to a more general discussion of the essential roles of the GP and the qualifications required for being one. Are medical knowledges and techniques the most important tools for a doctor, or should the GP also have certain character traits, such as empathy, a knack for 'clicking'[47] with his or her patients, and the capacity to differentiate between 'real' pathologies and 'false' ones? And what are the GP's limits? Should doctors treat all patients – no matter how rude, dishonest, and uncooperative they are? Indeed, doctors were very interested in discussing malingering patients on the one hand and patients who are unwilling to co-operate with the doctor on the other.

In his discussions with the doctors, Balint's approach was that the GP's role should be extended beyond its narrow definition as a provider of general medical services. He thought that 'the doctor's technique has both a medical and human aspect. He is a doctor and missionary who converts people towards a more realistic form of adjustment to life'.[48] Later on he would say that the doctor 'needs to educate patients towards a mature attitude to their illness'.[49] In explaining how one should fulfil this missionary role, Balint distinguished between two possible medical attitudes: the 'maternal' attitude, and the 'paternal' one. He did not explain in detail the difference between the two, apart from saying that the maternal attitude is a 'missionary function' with 'a major educational value', and that the paternal

[45] Second Session, 26 April 1951, p. 1 (GEN). The 'drug "doctor"' (Balint, *The Doctor, His Patient and the Illness*, p. 5) became one of the most notable Balintian notions.

[46] Second Session, p. 3.

[47] Ibid., p.4

[48] Ibid, p.6

[49] Third Session, 3 May 1951, p. 1 (GEN). Compare, however, with Balint's rejection of the 'educational model' in the training of GPs in psychotherapeutic tools in his late article, 'Psycho-Analysis and Medical Practice', *International Journal of Psycho-Analysis*, 47 (1966): 54-62.

attitude also has some educational value, but using this approach means providing less time and attention to each individual.[50]

At another meeting, the doctors examined 'the different reactions of patients to frustration'[51] caused by their conditions. Some patients, the GPs observed, develop 'pride' in their illness, which makes the doctor's life easier: 'they enjoy coping with their illness in an intelligent way. It is also probably a function of maturity'.[52] Balint replied that 'this is the way children are educated towards maturity', and added that there is a similarity between 'the doctor/patient relationship and the parent/child relationship'.[53] Strikingly, just at this point of the discussion, Dicks suggested that this sort of parental relationship is closely related to the notion of regression: 'you must allow a patient to regress first so that later he may be helped to mature'. 'Regression' became a significant concept in postwar British psychoanalysis, as I have demonstrated elsewhere. [54] The idea was that regressive states are not only a symptom of pathological mental states but also contain the potential of curing severely traumatized patients. However, notions of regression were widely used in medical discourses as we can see in this case.

'Can you do any better than we do?': GPs and the 'specialists'

In the next two meetings the doctors discussed their lack of knowledge in psychology and their lack of training in psychosomatic medicine. These deficiencies create, they said, a structurally inferior position for them in their professional contacts with psychiatrists. One of the main problems for doctors was that a lack of psychosocial vocabulary prevented them from diagnosing many of their patients' pathologies, even when they knew exactly what they were suffering from. But when one doctor suggested applying 'common sense' before sending a patient to psychotherapy, Balint strongly opposed the use of this term: 'what we must aim to do is "proper" therapy and nothing else'.[55] Balint and Dicks strongly encouraged the GPs not to feel any inferiority for their 'ignorance' in psychology, or to cover their lack of

[50] Second Session, p. 7.

[51] Third Session, p. 2.

[52] Ibid., p. 3.

[53] Ibid.

[54] See Shaul Bar-Haim, 'Regression and the Maternal in the History of Psychoanalysis, 1900-1957', *Psychoanalysis and History*, 16:1, 2014, pp. 69-93.

[55] Sixth Session, 24 may 1951, p. 3 (GEN).

knowledge with 'common sense'. Balint argued that 'the GP frequently knows better about his patient than the specialist, but […] he has not the courage to back up his knowledge'.[56] One of the aims of this seminar, added Dicks, was precisely to encourage GPs 'to think in holistic terms'—that is, to use their patients' psychosocial record (e.g., socio-economic background, family situation) to help them where the specialist could not.

Nevertheless, the GPs complained that although they can give 'better treatment than the specialist from the point of view of the total personality […], at the medical schools students are given the impression that all GPs are fools'.[57] It turned out that the doctors' problem was not only their lack of knowledge but also their poor professional status: 'if the GP gives a diagnosis that the hospital thinks is not serious, they will say they have no beds. It is necessary, therefore, to state a false diagnosis over the phone so that the patient may be admitted'.[58] Balint noted that GPs have a double apostolic function: converting 'both the patient and the specialist to his own belief'.[59] It is true that specialists have the skills to do things that the GP cannot, but the essential thing, Dicks noted, 'is that specialists must act in the service of GPs', and not the other way around. [60]

At that stage of the conversation, the GPs realized that Balint and Dicks were suggesting that they increase their engagement with psychotherapy not only as a form of treatment, but also as a necessary skill for improving their professional status. The GPs were encouraged to ask specialists 'can you do any better than we do?', when the answer, they believed, was very often no.[61] A few meetings later, in a discussion about pre-marital advice and talking about sexual matters with patients, some doctors were uncertain as to the limits of their duty regarding these topics.[62] Balint replied that 'it is exactly the same situation as if the

[56] Seventh Session, 31 May 1951, p. 2 (GEN).

[57] Ibid. In 1958, Lord Moran of Manton (the Dean of St Mary's Hospital Medical School and Churchill's private doctor) famously stated that GPs are doctors who wished to be consultants, but had fallen off the ladder: 'There was no other aim and it was a ladder off which some of them fell. How can you say that the people who get to the top of the ladder are the same people who fall off it? It seems to me so ludicrous' (M. Curwen, '" Lord Moran's Ladder ": A study of motivation in the choice of general practice as a career', *The Journal of the College of General Practitioners*, 7:1, 1964, p. 38.)

[58] Ibid., p.3.

[59] Ibid., p. 4.

[60] Ibid., p.7

[61] Eighth Session, 7 June 1951, p. 2 (GEN).

[62] Other doctors were more confident in discussing these topics with their patients, but not necessarily wiser: '[the doctor] had gone into the matter quite fully with her, asking her whether she had had any previous

doctor were considering an operation. Some operations can be done in the surgery, others have to be done by specialists. In such circumstances the doctor goes as far as he feels able.'[63]

Towards the end of the meeting, the GPs became much more assertive in their demand to extend their authority to include cases of marital problems. They argued that as family doctors they could do a better job than institutions such as the Family Discussion Bureau, and that time and money should be made available for this purpose.[64] Here again, the doctors realized how much potential the psychosocial approach held for promoting their professional status. Indeed, Balint and Dicks believed that GPs have the potential to apply psychosocial approaches better than anyone else in the medical professions because they had a holistic view of the patients: physiologically, psychologically, social-culturally, and even politically.

General practice and the model of paternal care

At this stage, it became clear to all participants that if the psychiatrist 'must pay regard to social, political and ethical factors', then so does the GP, and therefore general practice as a discipline needs to define its ethical core values. As one doctor put it, the question should be 'what are the ethical standards that the GP and the psychiatrist must subscribe to? Should we stick to the conventional legal, economic, and ethical code?'[65] Suddenly, the GP's ethics became the main focus of the discussion, and the doctors started to raise more and more specific ethical dilemmas for the groups' assessment.

One said, for instance, that psychiatrists often try to 'patch up marriages when it is really quite unrealistic to do so. Why should we necessarily try to keep a marriage together?'[66] It was suggested that in marital problems, as in other issues, the GP should provide the patient with alternatives before letting the patient make up his or her own mind. Balint, however, rejected this approach, saying 'that in certain cases one has to lay down

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relationships with boy friends and whether they included kissing, cuddling etc. He also asked her who was her famous [sic] film star and whether she would like to have sex relations with him.' (Ninth Session, 14 June 1951, p. 4 [GEN]).

[63] Ninth Session, p. 7.

[64] Ibid., p. 13.

[65] Eighth Session, p. 4.

[66] Ibid.

rules'.[67] Balint perceived the GP as a parental figure, which meant that, for him, the doctor had to take an interventionist position when necessary. In that sense, he adopted similar caring – as well as paternalistic and interventionist – approaches to the ones applied by the new welfare state in so many forms.[68]

Other ethical discussions focused on the 'clash between the happiness of the individual and that of the group'.[69] For example, doctors had certain views on whether to save the mother or the child when handling complications in childbirth. This discussion led one doctor to suggest that here a GP's opinion is no more correct than that of anyone else: 'no-one will adopt any particular code of ethics simply because he is a GP'.[70] Balint, however, was consistent in his interventionist approach, arguing that 'we do, in fact, lay down standards for other people, although we may only do this unconsciously. It is a function of these discussions to try to make these standards conscious'.[71] When GPs suggested that their ethics should match their patients' ethics, 'Balint expressed silent disagreement'.[72] He told the group of a suicide attempt, 'where the girl had taken drugs and would not open her mouth to have her stomach washed. As a last resort, the doctor boxed her hard on the ears', which caused her to open her mouth and saved her life.[73] He maintained that the GP has the responsibility to ensure that patients experience minimal suffering, and therefore he cannot always follow his or her patients' ethics, but must have his own ethical standards. The doctor, for him, was similar to a parent, who should not always listen to his or her child's will, as the child does not really know the potential dangers of his or her behaviour.

The idea of the GP as a parental figure was repeatedly promoted by Balint as a necessary model for understanding the ethics of the profession. In a discussion of the best way to give patients 'bad news', one doctor suggested that it is not always good to provide

[67] Ibid.

[68] See, for example, John Welshman, 'In search of the "problem family": public health and social work in England and Wales, 1940-70', *Social History of Medicine* 9:3 (1996), pp. 447-465; James Vernon, 'The Ethics of Hunger and the Assembly of Society: The Techno-Politics of the School Meal in Modern Britain', *The American Historical Review*, 110:3, 2005, 693-725.Chettiar, 'More than a Contract'; Denise Riley, *War in the Nursery*.

[69] Eighth Session, p.5.

[70] Ibid., p.6.

[71] Ibid.

[72] Ibid., p. 7.

[73] Ibid.

the patient with all the information. Balint immediately noted that this approach reminds him of a 'strict mother who knows what is best for her children'. [74] In another meeting, some doctors thought that when neurotics 'cannot benefit from psychotherapy', it is better to adopt 'the "strict father" attitude' with them.[75]

Another example of Balint's paternalistic approaches in medicine came when the GPs discussed their problems with un-cooperative Christian Scientist patients. One doctor said that 'it is a matter for the individual to decide, how he lives and how he dies'.[76] Balint replied that 'doctors had a mission to heal and also a mission to teach […]. It is part of the doctor's role to adopt an apostolic approach to convert the patients towards his belief'.[77] For him, the GP was a social agent whose mission goes far beyond medicine itself. Thus, there are some beliefs that the doctor should actively reject. It should come as no surprise, then, that given this tone, one doctor asked Balint 'whether [they] should also try to convert Communists and Fascists'.[78] Within the new Balintian interventionist approach, this question was not completely hypothetical. For Balint, the doctor should also have something to say on those issues.

The participants now turned to discuss abortions. They refused to carry out abortions because of their illegality, but supported the legalization of abortion. One doctor told the group about a patient who was separated from her husband but still 'lived with her family', who got pregnant. She wanted to have an abortion because she was dependent on 'her people', who would not be tolerant of her situation. The doctor suggested that he would 'send her away to have the child and that no-one would know anything about it, or else he would go and talk to the parents and talk to the neighbours, and do everything possible to help her except actually arrange the abortion'.[79]

In the discussion, a few doctors mentioned that some parents accept 'an illegitimate child very well', and some expressed the need to change public perceptions about illegitimate

[74] Third Session, p.4.

[75] Fourth Session, 10 May 1951, p.6.

[76] Ibid., p. 9. A similar discussion occurred several weeks later on giving childbirth advice to Catholics. See, Ninth Session, p.4.

[77] Eighth Session, pp. 9-10.

[78] Ibid., p. 10. Compare with the discussion about 'the difficulty of a Jewish doctor in treating Fascists or a Communist doctor in treating a Tory' (Second Session, p. 7).

[79] Eighth Session, pp. 10-11 .

children. Balint brought up a case from his work at the Family Discussion Bureau, of a girl who got pregnant by an American soldier while her boyfriend was away. When the boyfriend returned from the war, he accepted the situation, but they decided that they would give the child up for adoption, and then get married: 'this worked out very well but the consequence was that ever since the woman has been unable to forget that her child has been taken away from her'.[80]

For some GPs the problem was not necessarily the legitimacy or illegitimacy of the child, but the question of mothering. One doctor said that 'she always thought it a pity for pregnant women not to become mothers'.[81] She said that she always explained this to pregnant girls, and that they usually accepted her opinion. She also noted that she did not necessarily recommend an adoption, as mothers have a few months to decide on that, and 'usually by this time the mother is unwilling to give up the baby'. Balint immediately replied that 'evacuation during the war showed that bombs mean very little but the loss of the mother means everything'.[82] Within postwar psychosocial discourse, maternal care was often perceived as having far more influence on people's lives than any political catastrophes such as war or evacuation.

Conclusion: Balint and the postwar parental state

Historians of the human sciences have recently shown the close affinities between the 'psy' disciplines and the function of the state in setting the criteria for good citizenship before and after the Second World War. It was especially in the postwar era that the 'family' became a major focus for psychologists, psychiatrists, and psychoanalysts, as well as for policy makers and social commentators, who perceived domesticity as the key element in a new form of *civic virtue*. Michal Shapira describes the post-1945 years as an era of transition from collective to domestic citizenship, namely, 'instead of being a haven from the political world, the home here was the very place where democracy was being produced'.[83] However, the fear was more often than not that the home – what British psychoanalyst D.W. Winnicott describes as a 'good enough home' – will not be able to 'produce' these future democratic

[80] Ibid., p. 12.

[81] Ibid., p. 13.

[82] Ibid., p. 13.

[83] Michal Shapira, *The War Inside: Psychoanalysis, Total War, and the Making of the Democratic Self in Postwar Britain*, Cambridge, 2013, p. 136.

citizens without the right guidance of the state by and through different agents, such as the teacher, the social worker, the family doctor.

The state had to protect the family unit, but also the other way around. The perception was that the family should serve as a mediator between the state and the individual, especially because of the danger that the former might become too powerful, even totalitarian. 'Is it likely that the family group is going to disappear completely, and that all its functions will be taken over by the state?' asked the Swedish scholar and journalist, Torgny Segerstedt, in a London International Conference on Mental Health in 1948. And for D. R. MacCalman, a mental hygienist – who also participated in the same event – the question was: '[Is] the family unit surrendering its functions to the wider unit of the state, which has not yet learned to exercise them adequately?'. [84] Protecting the 'family unit' was perceived as crucial for creating 'autonomous, responsible citizens capable of upholding a version of representative democracy'.[85] The ideal of good citizenship as a form of personal maturity and responsibility could be achieved, many believed, only by creating a 'healthy' domestic environment.[86] A result of this was the popularity of new forms of state support in the domestic sphere, such as marriage welfare services, as well as the development of psychosocial approaches, psychotherapy, group psychology, and primary care.[87]

This is the right context, I argue, through which to understand the emergence of the Balint movement in the 1950s. It was an attempt to teach GPs a new psychotherapeutic vocabulary, which was developed by prominent British psychoanalysts after the War and which promoted parent-child relationships as a primary model of all sorts of social relationships. For Balint, as well as for other Tavistock fellows, GPs adopting a parental role with their patients were not only a necessary tool for providing better medical services, or a way of solving structural problems of general practice as a profession; they were also an expression of a wider ideology of 'welfarism'. Moreover, in many social domains, the new welfare state adopted an interventionist parental authority as a model of relationship between the state agents and its citizens. Paradoxically, one of the reasons why this specific form of

[84] Quoted in Toms, 'Political Dimensions of "The Psychosocial"', p., 102.
[85] Ibid., p. 104.
[86] See, for example, D. W. Winnicott, 'Some Thoughts on the Meaning of the Word Democracy', *Human Relations* 3:2, 1950, pp. 175 – 186.
[87] Thus, for example, Chettiar argues, 'marriage therapy services were often provided by government employees and made available as a condition of national belonging and workforce participation, which had the effect of legitimating the desire for a fuller and deeper private emotional life as a basic guarantee of citizenship' (Chettiar, 'More than a Contract', p. 591).

interventionism was so legitimate in the postwar years was the perception that a 'good enough family' is the best antidote to threatening political economies like Italian Fascism, National Socialism, and Stalinist Communism, which represented the major public political anxieties of that era, and for many decades ahead.[88]

Thus, under the new British social democracy, in the words of Rhodri Hayward, 'the whole population became the target for therapeutic intervention.'[89] The Balintian 'family doctor' demonstrates how the popularity of psychotherapy as a clinical tool for dealing with acute psychosocial problems, together with the emergence of a more interventionist welfare state, provided some GPs with an opportunity to reshape and extend their medical role into being a psychotherapist, a social worker, a social guide – but also to become the 'long hand' of the new welfare state in conducting what can be described as a form of 'pastoral power'. [90] According to Michel Foucault, the model for 'pastoral power is the Christian 'shepherd-God', who 'got to know his flock as a whole, and in detail. Not only must he know where good pastures are, the seasons' laws and the order of things; he must also know each one's particular needs'.[91] For Balint, I argue, the GP ideally served as a 'shepherd' in that sense that she should embody a medical and psychosocial guide not only for the individual patient but also for the family as a whole.

This is also the point where for Balint a distinction should be made between psychoanalysis and general practice. As he will argue in his later writings, psychoanalysis was designed primarily as a two-person treatment and it is most useful as such, while 'the doctor maintains a close therapeutic relationship with every member of the family, the intensity of which varies with the member's personality and with the urgency of his complaints, but it is hardly ever an exclusively two-person relationship'.[92] The idea that GPs

[88] In the words of Sally Alexander, 'maternal devotion, ordinary families in good enough homes as the basis for government, had become an orthodoxy – the maternal superego – of the post-war settlement; the political context in which they had been advocated (total war against fascism and Nazism, the need to strengthen the child's inner aliveness and creativity as the foundation of mature independent citizens capable of with- standing totalitarian or dictatorial forms of thinking) forgotten or never known'. See, 'D.W. Winnicott and the Social Democratic Vision', in Matt ffytche and Daniel Pick (eds), *Psychoanalysis in the Age of Totalitarianism*, New York, 2016, p. 127.

[89] Hayward, *The Transformation of the Psyche*, p. 78.

[90] See, Michel Foucault, 'Politics and Reason'. In: Foucault Michel, Kritzman Lawrenece (eds) *Politics, Philosophy, Culture : Interviews and Other Writings, 1977-1984*, Hoboken: Routledge, 2013.

[91] Ibid, p. 52.

[92] 'Psycho-Analysis and Medical Practice', p. 56.

should serve as a psychosocial authority for the whole family in his or her community exclude them from becoming quasi-psychoanalysts. It is also one way of understanding the confidence that Balint shows in some of the cases about the obligation of doctors to conduct authoritarian – and sometime interventionist – approaches with patients, as if they were children who need parental guidance.

However, a more balanced historical picture of the welfare state as not only a project of pastoral power but also of 'pastoral care' might conclude with Carolyn Steedman's description of growing up in South London where the state – and its many agents – intervened and enabled her early life:

> What my mother lacked, I was given; and though vast inequalities remained between me and others of my generation, the sense that a benevolent state bestowed on me, that of my own existence and the worth of that existence – attenuated, but still there – demonstrates in some degree what a fully material culture might offer in terms of physical comfort and the structures of care and affection that it symbolizes, to all its children.[93]

Steedman's memoir influenced scholars of postwar Britain partly because it problematized the idea that the welfare state was a progressive political project. As Bruce Robbins notes, 'at the contradictory heart of the book, ambivalence about Steedman's mother shades into ambivalence about the state and about the state's actions as, in effect, a parental surrogate'.[94]

It was in shaping this perception that the state is a quasi-parental entity that midcentury British psychoanalysis, and especially the new 'object-relations' school, could be so useful. For the 'object-relations' school, which Winnicott and Balint led in the 1950s and 1960s, the notion of *dependency* was a crucial one. That is, people are always already dependent on each other as is the baby dependent on her mother. As Donald Winnicott put it in 1952: '[If] you show me a baby you certainly show me also someone caring for the baby,

[93] Steedman, *Landscape for a Good Woman*, pp. 122-23.

[94]Bruce Robbins, *Upward Mobility and the Common Good: Toward a Literary History of the Welfare State*, Princeton, 2007, p. 162. For the great influence of Steedman's book on the historiography of the postwar era, see for example, Mathew Thomson, *Lost Freedom: The Landscape of the Child and the British Post-War Settlement*, Oxford, 2013, p. 6; Frank Mort, *Capital Affairs: London and the Making of the Permissive Society*, New Haven, p. 21; Geoff Eley, *A Crooked Line: From Cultural History to the History of Society*, Ann Arbor, 2005, pp. 172-81.

or at least a pram with someone's eyes and ears glued to it'.[95] Any other understanding of individuals as independent – so believed architects of the welfare state and psychanalysts after the Second World War – is an illusion, and therefore doomed to fail. Therefore, the popularity of Balint's interventionist approach and of the welfarist ideologies in the postwar decades are closely related. After all, visiting a GP is always a reminder of our fragility and dependency on other people – indeed on society as a whole. Doctors can use their medical knowledge in all sorts of ways, but according to Balint and his followers, against feelings of fragility and social anxieties, GPs can mainly do one thing: prescribe themselves, their medical and social authority, and their very own existence as psychosocial guides. That was the real meaning of being a 'drug "doctor"' in the age of the British welfare state.

[95] Donald W. Winnicott, *Collected Papers: Through Paediatrics to Psycho-Analysis*, London, 1975, p. 99. On Winnicott as a postwar social democratic thinker see, Alexander, 'D.W. Winnicott and the Social Democratic Vision'. Winnicott's emphasis on *dependency* as a fundamental element in any form of social relations – indeed of any social contract – echoes other commentators and political thinkers in the postwar era, who thought that there is an urgent need in re-thinking the glorification of *independency* in Western culture. See, for example, Hannah Arendt, *The Human Condition Book*, Chicago, 1959; Norbert Elias, 'Introduction to the 1968 Edition', *The Civilizing Process (Volume 1): The History of Manners*, Oxford, 1978. On Elias's great interest in group dynamics after the WWII, see, Pick, *The Pursuit of the Nazi Mind*, pp. 192-194.