The International Balint Federation

Proceedings of the
20th International
Balint Congress
6-10 September 2017

The Balint Society

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Proceedings of the

20th International Balint Congress

held at Keble College, Oxford, UK

6-10 September 2017

Edited by

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and

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Acknowledgements

I would like to thank all the speakers in advance of the congress for their contributions, and those whose papers are presented here, but not being delivered at the congress.

I am grateful to my colleagues on the organising committee, Ceri Dornan, Caroline Palmer and Martin Tilling. To the leader of the scientific committee, Paul Sackin and all its members and readers, who have done an extraordinary amount of work selecting and editing the papers. Also to the members of the Council of the Balint Society, the Balint Society's leadership group (headed by Jane Dammers), and the IBF Leadership Task Force (led by Tove Mathieson).

David Watt July 2017

Preface

The original idea for the UK to host the IBF congress again, 19 years since 1998, came from the Secretary of the Society, Ceri Dornan. As the only Balint Society council member left who had worked on that congress, I was easily persuaded to participate. We had so enjoyed the last congresses in Heidelberg, and in Metz, and wanted to do another slightly contrasting event. We were lucky enough to also have the help of Paul Sackin, now General Secretary of the IBF, who had also worked on 1998.

We decided to work with the theme, "**Balint Theory and Practice: Exploring Diversity**", and to try to get presenters to focus on this (the next page shows the original call for papers). We had the idea of diversity in really two meanings. That of the more political connotations; race, creed, colour, sexuality etc. But also of difference in kind of groups, their members, and their particular settings, from medical schools to years long running groups of GPs meeting in the community as originally envisaged by Michael Balint in the 1950s, from the "leafy" suburbs of the UK to countries experiencing, or recently having experienced warfare or civil war.

We did not invite any "outside" lecturers apart from the poet, Padraig O Tuama, keeping the arena for research work from members of the IBF from all around the world. We also decided to have a "workshop" session, which seemed very appropriate to the thinking around the conference theme.

The organising committee hopes that you enjoy the paper sessions, including the student Ascona Prize Essay presentations on Saturday, when students will be having a parallel study day alongside the congress, joining us for paper sessions, but having Balint groups in the afternoon, when the congress hosts the IBF General Assembly. Also, that you enjoy the small group work, organised with the help of the IBF Leadership Task Force and the UK Leadership Group, and do not regret too much the lack of space for a whole congress "demonstration group", which we have decided against, particularly as we are all living together in college for the duration of the Congress.

David Watt July 2017

Call for Papers, Posters and Workshops

20ᵗʰ International Balint Congress
Oxford, UK, 6ᵗʰ to 10ᵗʰ September 2017

On behalf of the UK Balint Society and the International Balint Federation (IBF), the Scientific Committee would like to invite you to submit Papers, Posters and Workshop proposals on the theme:

Balint Theory and Practice: Exploring Diversity

Word cloud art created via tagul.com

This is an opportunity for international colleagues to consider the benefits and challenges brought to Balint groups by having patients, members and leaders from diverse cultural, professional and personal backgrounds.

Diversity is all around us, but talking about it can be difficult. We think that an IBF Congress is just the setting to do it. Here are a few examples of questions that the Congress might address, but there will be many more:

- As more countries and professions join the Balint movement has underlying theory been adapted and with what effect?
- What are the challenges in a group when the social or cultural identities of the patient, presenter, participants or leaders are relevant to the case?
- How may different professional cultures affect the work of multidisciplinary groups?

We look forward to reading your ideas through submission of Papers, Posters and Interactive Workshop proposals.

IBF Congress Oxford 6-10 September 2017

Balint Theory and Practice: Exploring Diversity-Agenda

Wednesday		
		1-3pm Conference Group Leaders Meeting (1)
2pm	Registration open	Sloane Robinson Building
3pm	Tea available	
4-5:30pm	Welcome & Introductory Lecture O'Reilly Theatre	**Don Nease, Tony Berendt, David Watt** Poet: **Padraig O Tuama**: "Where there is silence, let there be story."
5:45-6:45	Orientation to Oxford walk	John & Mary Salinsky
7:00	Reception & Dinner(8pm)	Liddon Quad Dining Hall
Thursday		
8:30-10:30	Paper Presentations 1 Theatre	1. "Balint the Internationalist : Featuring the Michael Balint Archives" **Dr Andrew Elder, Dr Esti Rimmer, Dr Raluca Soreanu, Judit Szekacs** 2. Aspects of diversity: the different, the strange, the distant, the unfamiliar and the incomprehensible in Balint work. **Nina Arzberger** 3. Choosing borders: laying the landscape of Balint in Pakistan. Muhammad **Shameel Khan and Aisha Sanober**
10:30-11	Coffee	
11-12:45	Group 1	
12:45-2	Lunch	
2-3:30	Workshops	
3:30-4	Tea	
4-5:30	Group 2	
6-7	Organ/Music Recital	Chapel
7:30	Dinner	9-10pm UK Balint Society AGM Douglas Price Room

Friday		8-8:45 Leaders meeting(2)
9-10:30	Group 3	
10:30-11	Coffee	
11-13:00	Paper Presentations 2 Theatre	1. Wise and not so wise reasoning: A Balint group project for anaesthetists at a Stockholm hospital. **Henry Jablonski and Elsa Lena Ryding** 2. Balint group work as serendipity. **Henry Jablonski.** 3. Balint groups as a method of prevention of professional stress in mid-level mental health workers. **Anzhela Avagimyan** 4. Balint groups for palliative care therapists: treating in the shadow of death. **Yuval Shorer, Stanley Rabin and Andre Matalon**
13:00-5	Lunch and free period	
5-5:30	Tea	
5:30-7	Paper Presentations 3 Theatre	1. Experiencing common issues and cultural differences leading Balint Group sessions in Guadeloupe: **Isabelle Martinot Nuet** 2. Hosting diversity: challenges in leading multidisciplinary Balint groups. **Alice Polomeni** 3. Exploring diversity in remote areas of Australia's Northern Territory: Balint in the never never via telephone. **Frank Meumann, Bambi Ward and Richard Fejo**
7:30	Dinner, followed by Live Music/Dancing in Bar (9pm)	

Saturday		8-8:45am Leaders Meeting (3)
9-10:30	Group 4	
10:30-11	Coffee	Parallel Student Day Starts
11-12:30	Paper Presentations 4 Theatre	1. Discovering my white male privilege: becoming an ally – continuing my education. **Jeffrey Sternlieb** 2. Medical acculturation of doctors, their patients and the Balint group. **Diana Bass.** 3. Practicalities of diversity in a Balint Society. **Katherine Knowlton**
12:30-1:30	Lunch	
13:30-4:30	IBF Assembly Meeting	Theatre
4:30	Tea	
5-6:30	Ascona Prize Presentations Theatre	1. Meeting Margaery**:** **ElizabethHamilton** 2. From Regression to Progression: a medical journey towards a professional identity**: Nuphar Vinegrad** 3. George**: Michael Watson**
7:30-10:30	Conference Dinner & Singing	Dining Hall
Sunday		8-8:45 Leaders Meeting (4)
9-11	Group 5	
11-11:30	Coffee	
11:30-1	Plenary	Theatre
1pm	End of Conference	1-2pm Last Leaders Meeting (5)

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Wednesday afternoon

Speeches of welcome from:

Dr Don Nease, President of the IBF, Dr David Watt, President of the Balint Society(UK) and Dr Tony Berendt, Medical Director of Oxford University Hospitals (not presented in this proceedings)

Thursday morning

 Dr Andrew Elder, Dr Esti Rimmer, Dr Raluca Soreanu, Judit Szekacs

Nina Arzberger, Ph.D., Vienna, Austria

Dr Muhammad Shameel Khan, Dr Aisha Sanober

Friday Morning

Henry Jablonski and Elsa Lena Ryding

Henry Jablonski

Anzhela Avagimyan

Friday afternoon

Saturday Morning

Saturday afternoon

ASCONA PRIZE ESSAYS:

Papers not delivered at Congress

Workshops Taking Place at the Congress

1. WORKING WITH DIVERSITY AND DIFFERENCE IN BALINT GROUPS – THE PATIENT, THE CLINICIAN, THE LEADERS AND THE GROUP.
   Jane Dammers, Ami Kothari and Judy Malone
2. BALINT THEORY AND PRACTICE: EXPLORING THE INTRODUCTION OF BALINT GROUPS FOR HEALTH PRACTITIONERS WORKING WITH PEOPLE FROM DIFFERENT CULTURAL AND ETHNIC MINORITY GROUPS.
   Frank Meumann, Bambi Ward and Richard Fejo
3. WHO HELPS THE HELPER? THE OPPORTUNITIES OF AN ART THERAPY BALINT GROUP.
   Feher Palma Virag
4. DEVELOPING CULTURAL HUMILITY.
   Jeffrey Sternlieb and Katherine Knowlton
5. BRINGING SEXUAL and GENDER DIVERSITY CASES AND DIVERSE SEXUALITY AND GENDER OF GROUP MEMBERS AND LEADERS INTO THE WORLD OF BALINT.
   Timothy McMichael.
6. STARTING A NEW BALINT GROUP – WHAT ARE WE TO EXPECT, AND IS IT WORTH THE EFFORT?
   Amos Ritter
7. THE BALINT 2.0 INTERNET GROUP: AN INTERNET FISHBOWL WORKSHOP.
   Albert Lichtenstein and Donald Nease (leaders) and Andrew Elder (facilitator)
8. DEMONSTRATION BALINT GROUP:
   Balint Society UK, Leaders to be announced

Where there is silence, let there be story.

Padraig O Tuama

> When we tell a story we exercise control, but in such a way as to leave a gap, an opening. It is a version, but never the final one. And perhaps we hope that the silences will be heard by someone else, and the story can continue, can be retold…When we write we offer the silence as much as the story. Words are the part of silence that can be spoken. [1]

Years ago, at work one day, I got a phone call to say that somebody wanted to speak to me and could I come to reception.

At this stage I was working as a chaplain. It was a busy job, with internships and university groups and people. There was religion everywhere, and everyone who worked in this job was expected to be particularly religious.

I asked what it was about and the receptionist said to me "Just come. Someone needs to talk with you."

So I walked up to reception, and as I walked I saw a man I'd never seen before.

He was moving, as if highly anxious, a small framed man, I would guess around the same age as me. I bet he's gay I thought, and I bet he's come to make his confession to someone he hopes will absolve him.

I invited him back to my office. We sat and spoke for a while. He spoke of this and that, and then he started to speak about how he likes going to religious services, and then he spoke about one particular service and then he spoke about how after one of the services he had been invited back to the house of one of the leaders of the church and how later, when he was putting his clothes back on, his hands were shaking so much he couldn't tie his shoelaces or button up the buttons on his shirt.

Then he looked at me and said "Could you tell? Could you tell? Could you tell? When you saw me, could you tell?"

All of this was a long time ago and a long way away. I lived in a different country where we both were foreigners.

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[1] Jeanette Winterson, Why be happy when you can be normal? London: Jonathan Cape, 2011. pg. 8

I am gay myself and while I was clear in my own mind that this was the case, I kept on taking jobs in conservative religious contexts that would have fired me sooner than entertain the idea that a gay relationship had a moral code to its love.

Nobody knew, as far as I knew.

I was sitting watching him, not wondering about him, but wondering about the receptionist. She had encountered this distressed man. Truth be told, she was a pretty woeful receptionist, regularly getting phone numbers wrong, opening private mail and disappearing for long periods of time. And even though I wasn't the on-call person, she had called me anyway. How did she know what to do? I wondered, wondering whether I was more obvious than I thought or she more subtle than she seemed.

The man was still in front of me, sitting on a sofa, twisting his fingers around his fingers, wondering if I could tell that he was gay.

Of course I could tell. But I couldn't tell him.

No, the chaplain lied, I thought you might have had money trouble.

I gave him a truth that he might have been able to cope with. He had a girlfriend and liked chatting with guys online, and had been charmed by the church leader's attention and mostly seemed distressed that the church leader was very attractive. He was overwhelmed with curiosity about sex and men's bodies, and this experience — consensual, he repeated — was nonetheless not the fantasy he had had, and now that his first time was over he was over and he thought he should tell his girlfriend and ask her to marry him if he could get counselling. But I'm not gay, he said. I'm not gay.

After he left, I never saw him again.

All of this makes me think about the question of identity.

A friend of mine, years ago, wrote a piece for a newspaper. It was the simple repetition over and over:

I am a writer. I am a writer. I am a writer.

It was her brave defiance, and while it was obvious to anyone reading her that she was a writer, it was clear that she had had a dream of what a writer should be, she wasn't living that dream, but nonetheless wanted to claim the identity of writer. I don't

think anyone would have disputed the claim, except herself, and that was the main point.

In any given day we might find ourselves conjugating the verb "to be" in many different ways.

I am awake.
I am unemployed.
I am stressed.
I am happy.
I am trying to do my best.
I am a doctor.
I am a woman.
I am alive.
I am dreaming of changing my life.
I am gay.
I am unhappy.

In Irish, if I were to say "I am sad" I would say "Tá brón orm" - which is to say "Sadness is upon me". Sadness is like a cloak wrapped around me. But happiness can be another cloak.

I prefer this way of speaking, because I think the phrase "I am" can imply something too fixed, too singular about identity. Identity, the way I think of it, is a word too similar to Identical. It bothers me. I am barely identical to myself, and the self I think I am is probably not identical to the self I might be, or am.

So many things — including identities — are temporary, and many things exist all at once.

What does this have to do with you?

I am ill, some people say. In Ireland, people tend to use the word "Sick" rather than "Ill"., so we'd say "I'm sick". Even the English word might come from middle Irish *socht* which while meaning unwell also carries a connotation of silence or depression. Silence is on me. Depression is on me.

I work at Corrymeela, Ireland's oldest peace and reconciliation organisation. Begun in 1965, Corrymeela was a place set up to facilitate people of different religious, national and political identities in friendship and understanding, argument and civility with each

other. . Facilitate. From French: facile. Ease. To make easy what, in the pre-troubles years of the 1960s, was not easy then, and it was about to get a damned sight more difficult. We work with people to tell their stories of sectarianism, to face down silence and sickness, depression and denial

For 52 years now, Corrymeela has provided a place of dialogue, argument, mealtimes, political disputes, accusation, pain, forgiveness, resentment, wounding and healing. Something is arrested when a person becomes a victim. Something happens in a body when a person knows that their story is not believed, and their story as victim — understandably — becomes the skin they wear to the world. We know a lot about listening, and a lot about what happens when someone tells their story to someone they never thought they'd tell their story to. Something happens in a body when a person feels believed.

One time a woman whose story had been systematically denied went to a trampoline we used to have on our grounds and bounced and bounced and bounced and said "Fuckers! if only the neighbours could see me now!" Something had been facilitated in her. Some kind of silence.

It isn't so much that we need to see others. It's that we sometimes need to see others seeing us, or see ourselves seeing ourselves, and find something life giving under this cloak of invisibility that can be so difficult.

We work with about 10,000 people a year on programmes of dialogue, argument, justice, training, faith and practice. And mostly, what we know, is that we need the careful skill of listening, facilitating, and speaking. All of this is another way of saying that we do storywork. And storywork begins from the moment someone contacts us, phones us, emails us, saying they want to be on a programme. It is an art of reading the words and letting the words unfold their many meanings.

In the introduction to The Anchor Book of New American Short Stories[2] Ben Marcus said that there are only two stories: a person goes on a journey or a stranger comes to town. This can all sound very nice, but when someone is killed, or when you've found yourself killing someone, or you've found yourself with some new identity like perpetrator or victim or survivor, there is a journey and a new destination that you never wished to happen.

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[2] New York, Anchor Books, 2004

Where do you begin the sentence? "My son was murdered" or "It's their fault" or "I was young" or some other awful words you wished you could never use. Another theory about storytelling is that there are seven basic plots to the stories humans tell. Another theory is that there is only one plot: who am I?

I've been speaking at conferences of Nurses run by the Queens Nursing Institute in Scotland in the last year, looking at how it is that Corrymeela evokes stories from people and pays attention — through listening, poetics, and narrative structure — to the ways in which people tell their stories, to the power dynamics that occur when people have a story to tell and what certain people to listen to it. They asked would I write an article about it, but one of my stories is that I'm a better poet than I am article writer, so I wrote a prose poem instead. A prose poem looks like an essay, but writes in such a way that it follows the logic of poetry while using the visual form of paragraphs. This prose poem — Patient Notes — is not short, but it's true. Or at least most of it is mostly true, some of it even about me. It's called "Patient Notes" and it seeks to trouble the idea of singular stories about ourselves, and looks at the space that happens when human encounter surprises us and we are skilled enough to bear witness to the dignity that that surprise deserves.

Patient Notes.

Here's the thing. While I have my asthma under control and my sleeping is no worse than usual, I am still near the uaigh. That's the word for grave in Irish, and it's also part of the word for loneliness. I'm near one or the other, or both. There was a time when my health was the only thing I talked about, and my friends from that time ask me now, and I remember that that was the person I was; when health was a fear, because pain was my first language.

But what's really bothering me is the way I use the possessive when it comes to my asthma, my insomnia, my thinning hair, my symptoms. It makes me think I think I am these things. Am I? I wilt therefore I am? If they are me, where will I go if I lose them?

I remember when I learned the word ontology – the study of the nature of being. If I am sad, is sad me? If sad is me then what happens when someone treats my sadness? If we were all speaking Irish we would say that sadness is on me. But we're not. Because when I was five I asked where English came from and my parents introduced me to stair. If we all spoke Irish we would say stair instead of history. But we speak English, mostly, and so stair is relegated to something we use to get up or down, never a story. Did you know that I carry my people's history in my bones? People didn't believe me when I said that but then scientists wrote about it, and discovered what was already there — inherited in the blood, the bones, the DNA, the genomes, the chromosomes,

like thinning curly hair, like weak lungs, like poetry, like insomnia — and it's all the rage now, that codified stairstory inside us.

Once when I was waiting on a trolley I kept on trying to get up even though I knew I'd fall down. So they put an orderly to mind me. Well, he was there to restrain me, but I didn't mind. He was young and eager to be seen to be good with patients. I asked him how long his shift had been and he said it was his first. After a bit of this and a bit of that he told me he wasn't sure he'd come back for a second. I said Ah Son. I said it because I felt it even though I don't have any sons. All of his need was raw in front of him. And my words, out of my mouth, were more surprising than anything else I heard that day. Turns out, I was happy to wait with him. He has tattoos all over his skin — quotes and quotes from poems. Stories written on the body, like a skinscripture.

Just like all of us.

When I asked the nurse her name she said she shouldn't tell me but she would, provided I stopped being a pain in her ass. You call me by mine, I said. And she said, I know. Then she said swallow these, try to get some sleep. If you need anything, call me. Call you what? I said. Verity, she said. I tried to believe.

Having my blood pressure taken, I noticed that the cuff was sponsored by Viagra. Nice sponsorship I said. The nurse looked down. Keeps your arm straight, she said – and then she snorted – I can't believe I said that, she said, we must know each other from another life.

Another life. Sometimes that sounds nice.

And another time, in another surgery room, a doctor noticed I was reading a book of poems by Emily Dickinson. I always hated her, the doctor said. I said that I never understand her, that's why I love her. Are you a poet? she asked. I used to be, I said. She said, Where's the poet now? I said Lost. Then she said What rhymes with Lost? I said Frost. Then I said Tossed, Provost, Accost, Crisscross, Holocaust. She looked at me. You forgot to say Cost, she said, pull up your shirt, let me listen to your heart.

On my way home, I wrote rhymes on the back of my hand with a biro I found in the bottom of my bag.

All this time and I've not told you what I do. I'm a business owner.

Ontology again. I'm a nurse. I'm a banker. I'm a shelf stacker. I'm an orderly. I'm a failure at the plans other people had for me.

Verity means truth so here's some. Sometimes, on rare occasions, I know that I am a small corner of a world that involves love and poetry and breathing and rest and friendships and late night curries made from scratch washed down with

bubbles and conversation. Most of the time, I'm just a man in front of a computer trying to stay alive.

Once at a dinner, I met a man who fitted blinds. Around the table were a bishop, a poet, a teacher and the man who fitted blinds. Nobody had more light than the man who knew how to keep the light out. I don't remember his questions. I do remember his curiosity. Ábhar le ionadh in Irish, watching with wonder. Where did he find the wonder to watch?

Back in the waiting room. A little boy sitting next to me, with a woman next to him. Sitting with my book of poems, I feel a touch on my hand. Mister, he says, where is your pain? I look at the woman to see if she has something to say, some way of saving me from the story I don't want to tell but need to tell. The woman flushes. She opens her mouth. Then she stops. She seems to decide. She looks at me. She waits. I look at her. I look at him. Mine's in my heart he says, moving his hand from touching mine to touching his small torso. Mine too, I say, listening to the roar of my blood.

When did you last have sex? the doctor asks. Then she smiles. It's not an offer, just a question. This morning, I say, blushing. Mornings are good for love and touch, she says. Keep it up.

Treatment. Treat. Treating. Let's begin your treatment the doctor said to me. I said to him that the treatment began with the man who didn't believe in verity. I could tell you what I mean, but if you don't know, then I don't know. If you know, then I know too. Sweets for the young. Sours for the sad. Treats for some. Treat the rest.

Last story. Lie back, the doctor said. I felt his cold hands pressing my stomach. Sorry they're cold, he said. He kept pressing. When he pressed near my belt, it happened. A memory hidden in the muscle flooded me and I am

Frightened. Shocked. Spasming. Tense. Afraid. Lonely.

Something I hadn't remembered that I remembered is remembered in my body and my body is my brain now, and my body has remembered. The doctor looks at me. He knows. He has heard my body too. He is quiet. He has stopped pressing. He looks me in the eye. Would you like a glass of water? Anything, I say, Anything.[3]

The I in this poem keeps moving. The I is clearly in deep distress at chronic illness, and is also distressed at the possibility of treatment. The I is finding surprise in waiting rooms and in penis jokes with nurses. The I is at times in deep need and at other times

[3] Pádraig Ó Tuama, 'Patient Notes' International Practice Development Journal, Volume 7, Issue 1, Article 11, May 2017

meets others in deep need. The I is surprised by what the I is saying and the doctor is picking up on moments of truth that are as deep as a virus in the patient. The doctor notes the patient's words and by noting them, helps the patient pay attention to the patients own self. The patient, too, is paying attention to others. The I cannot bear the idea of a child with a heart condition, even though the child with a heart condition can bear it. The I has a story stored in the body that the doctor touches, and the doctor knows what the doctor has touched, and the doctor listens. And the story ends by trespassing upon the great silence that the I has been gathered around all the time, going from medic to medic to avoid the story that was hidden in the body all along.

You know this very well. The ways in which a person is desperate to say to you that they are more than their symptoms even though they may believe in the deepest part of themselves that they are no better than their symptoms.

So here's another story. When I was five, I asked my parents why everyone in Ireland doesn't speak Irish. I don't know what language I asked this in — it could have been either Irish or English — and so began the need for bedtime stories about colonisation.

The word colonisation means something to do with a field. It seems to imply that someone came and took a field. I like this, because a field is personal. It is where a person lives, farms, sleeps, gives birth, eats, dies. In this way we see that all colonisation is personal and that the political is the personal. It began with the introduction of National Curriculum in the 1800s that forbade the teaching of Irish and a famine that devastated the country meaning that one million people left and one million people died in the space of four years and the population went from eight million in 1839 to four million by the end of that century. *Tír gan teanga, tír gan anam*, we say in English — a land without a language is a land without a soul. it is when you become foreign to yourself that you begin to forget yourself and when you forget yourself you can do all kinds of things to others and yourself because you aren't yourself anyway.

What does it mean to have your own mother tongue? And why do we call it a mother tongue anyway? Partly, I think, it's because of the way that language is passed from parent to child. But I also like the idea that a Mother Tongue can Mother something for us. It can be a creative force, a teaching force, a protective force, a strong force, a way of taming what is not known and naming what has been a surprise. We can mother with our tongue, I think. Or we could, if we would only try.

To language our need is part of the project of being human. We seek ways in which we can say truths to ourselves, and we hear stories break out of our bodies in a way

that changes us. Arundhati Roy believes that this process of telling stories is bigger than the telling. She says

> Writers imagine that they cull stories from the world. I'm beginning to believe that vanity makes them think so. That it's actually the other way around. Stories cull writers from the world. Stories reveal themselves to us. The public narrative, the private narrative - they colonize us. They commission us. They insist on being told. Fiction and nonfiction are only different techniques of story telling.[4]

Jeanette Winterson says something similar when she writes, commenting on her own story, and the fictions she sometimes uses to tell her own story:

> It took me a long time to realise that there are two kinds of writing; the one you write and the one that writes you. The one that writes you is dangerous. You go where you don't want to go. You look where you don't want to look.[5]

This is the kind of storytelling that takes courage. It asks us to tell all the parts of ourselves, the conscious and unconscious, the victim and the perpetrator, the part of us we like to tell and the part of us we don't like to tell because it tells much more about us than we want to tell. All of this might sound something like confession, if confession were a good thing, if confession were not about public shame but about the truth of the way things are.

In his poem '10.30 a.m. Mass, 16 June 1985', Paul Durcan describes a priest who said the mass. Because it was Father's Day, the priest told a story about his own father as part of the homily. The priest tells the congregation about how his father only liked one thing more than a pint of Guinness: two pints of Guinness. But the priest's proud father had given up drink as a way of giving thanks for his son's vocation to the priesthood. The priest described his dad's death:

> He died from cancer
> A few weeks before I was ordained a priest.
> I'd like to go to Confession - he said to me:
> OK - I'll go and get a priest - I said to him:
> No - don't do that - I'd prefer to talk to you.
> Dying, he confessed to me the story of his life.[6]

In his poem, Durcan takes a word that surely has been felt as a scourge on many people — confess — and brings it to a deeper meaning. In Irish, the first person

[4] Arundhati Roy, 'Come September', *The Algebra of Infinite Justice,* Flamingo, 2002.
[5] Jeanette Winterson, Why be happy when you can be normal? London: Jonathan Cape, 2011. pg. 54
[6] Paul Durcan, '10.30 a.m. Mass, 16 June 1985', in *A Snail in My Prime: New and Selected Poems* Harvill, 1993.

singular conjugation for confess is "Admhaím". It means to acknowledge, to admit, to concede, to accede, to grant or allow, to reveal, to declare, to make known. It is, a mothering thing to do. It is what baptism might mean if baptism meant this, a daily practice of courage naming.

In the Lord of the Rings, we hear of a character called Treebeard.

> For one thing it would take a long while: my name is growing all the time, and I've lived a very long, long time; so my name is like a story. Real names tell you the story of the things they belong to in my language, in the Old Entish as you might say. It is a lovely language, but it takes a very long time to say anything in it, because we do not say anything in it, unless it is worth taking a long time to say, and to listen to.[7]

So our names and our stories are long and many. They are plural. They change. They develop. They evolve as we evolve. We are not one person. We are plural.

The Christian religious texts contain many disturbing stories. Here's one. A man is chained up outside a village and he is howling. In fact, he isn't chained up. He was chained up but he broke the chains. He kept howling. He never re-entered the village. He howls all night and all day and no one can restrain him any more. He gashes himself with stones. When asked his name he says "My name is Legion, for we are many."

Legion is a Roman term, a garrison of 2000 soldiers. This man is in the pagan territory of the Gerasenes, an area known to have been occupied by Roman forces who marched under the standard the Swine, a garrison known to have practiced a scorched earth policy. This was a region in civic distress, and the distress seems to have been projected into the life of one man in the village who embodies, in his own story, the very anxiety being held by a region under military occupation.

It is easier to hate something that you can hate, rather than hate something that might destroy you.

No wonder the people found it easier to chain him up, rather than try to chain an occupying army up.

No wonder he howled.

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[7] J.R.R. Tolkien, *The Lord of the Rings.* Harper Collins, 1995.
Merry's and Pippin's encounter with Treebeard, the Ent, is found in The Lord of the Rings: Book 3, chapter 4.

No wonder, too, that when asked his name, he replied that he was the name of the thing that that was destroying his people.

My name is Legion, for we are many. He was the face of the thing that his townspeople couldn't face because of the threat that they were under.

In this way, the so-called *symptom* of one is actually a moment of apocalypse of the many. It is the curtains-back, under-the-carpet truth-telling that many would rather not hear about for fear.

This reminds me of Gollum, in *The Lord of the Rings,* who also forgot his own name:

> They cursed us, and drove us away. And we wept, Precious, we wept to be so alone. And we only wish to catch fish so juicy sweet. And we forgot the taste of bread, the sound of trees, the softness of the wind. We even forgot our own name. [8]

All of this — everything I'm saying — is a repetition of the same thing: Our stories tell us more than we think our stories tell us.

Single sentence stories. Long stories. Opening sentences of stories. Sentences from the middle of our stories. The names we give our stories, or, to say the same thing a different way, the names we give ourselves. Our fears, our hope, our health. They are all at the heart of the stories we tell.

Here's another story:

When I was in my late 20s, I was living in Australia and one evening I got a phone call from home at the wrong time. We always spoke on a Sunday but this phone call came on a Monday night. That was not a good thing.

It was my mother, phoning to tell me that my best friend from childhood — Cathal was his name — was dead.

Even as I'm saying this, I'm struck by the past-tense that I have to use. When writing this I wrote and rewrote the sentence "Cathal was his name" in many different ways to see if I could say it in a way that wasn't so stark. Anyway. It's stark. He was dead. He had taken his pain and his fear and his hope and his courage and his desperation and

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[*] These words of Gollum's are found in the screenplay of *The Lord of the Rings. The Return of the King,* by Fran Walsh, Philippa Boyens, Peter Jackson, and J. R. R. Tolkien (Cinemarket, 2003).

he had hung himself and all of those from the ceiling of the garage where we used to smoke cigarettes without inhaling.

I was on the other side of the world, working as a youth worker, broke, and even if I had the money, I wouldn't have made it home in time for the funeral.

Grief, you know, brings out all kinds of things in all kinds of people. I was in the awful situation of having to introduce Australian friends of mine to my childhood best friend through a story of suicide. Some of my friends in Australia listened. I was struck by how many people met my story of grief by telling me stories of griefs of their own that were unfinished. And I was also struck by how many stories on the immorality or selfishness of suicide came to me.

I wanted none of these. I took a few days off work and I walked. I didn't know where I was walking. Nowhere pretty.

I walked into the city one night. About eight miles. On the way a man asked me if I knew Jesus Christ as my personal Lord and Saviour. I tried to ignore him but he wouldn't leave me alone, even when I told him I was a man in grief who didn't need his interruptions. I kept walking and he stopped following.

I walked to the late night bookshop and found myself standing looking at The Lord of the Rings. I opened the book to a place where one of the characters is dead and the other characters are asking one of the bereaved to sing a lament. He says he will not because the grief is too near, a matter for tears and not yet for song.[9]

It was the only thing I could turn to: a fiction, but a fiction that was more true than anything else I was experiencing those days.

While I was leaving the bookshop I decided to take the train home rather than walk. On my way to the train station I noticed a man who seemed distressed on the footpath. He looked bewildered and frustrated and anxious all at once — looking up as if to find some kind of guidance from street signs. I went and asked if he was okay and when he answered it was clear he was deaf. I have loved sign language since I was a child — to me, that language is like living etymology, choreographed on the body — and have a few dictionaries of sign language. So, while my Sign Language is awful, I am skilled at making bad mistakes in it. We began to speak with each other. He told me he was French, and was lost in the city. He had arrived that day and had taken a train

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[9] Legolas' reluctance to translate the laments for Gandalf comes at the end of the 'Mirror of Galadriel' chapter, The Lord of the Rings (HarperCollins, 1995).

to the city centre, and now couldn't find his way back to the station. I said he could come with me because I was going that way. Irish Sign Language and French Sign Language have a lot in common. Somehow our languages linked us, even broken ones.

He relaxed a lot. And then he began to imitate my cumbersome sign language. I was all practice and precision, no fluency. He started to mirror my signs and I told him to shut up, and he laughed and for a small moment I forgot everything and was in a pure moment of kindness. He was charming, and handsome and funny, and full of chat and patience. When we got to the station, he took both of my tired hands in his warm fluent hands and held them, and looked at me, laughed out loud, and walked away.

And this was a story I could tell in the middle of a story of hell. It didn't change it, much, but it did accompany it, a little. When I think of being lost and lonely and bereft and surrounded by religious idiocy, I think of my dead friend, and the Lord of the Rings and the Deaf Frenchman. It is a way that a story weaves itself into a fabric that is continually changing.

It doesn't answer much. But I'm not sure answers are always the answer. I'm not even sure I was asking a question. I was walking, looking for some kind of gesture, some kind of liturgy, some kind of sacrament that could give space and dignity and voice to a story that was awful.

And even though the Frenchman knew nothing about my grief, he was the moment of human encounter.

Adrian Van Kaam said that Human Encounter is the essence of cure, in the deepest sense.[10] He was a psychotherapist who was frustrated at his lack progress with some of his clients. He bumped into a client one sunny day, in a park, and the sun was shining and the client came out from under a tree, said hi, they exchanged pleasantries and passed on. When the client came to the end of their time as a patient of his, the client said that those pleasantries under a tree on a sunny day were the most important of their encounters. This is why Van Kaam said that human encounter is the essence of cure in the deepest sense. But this human encounter would have meant nothing without all the expectation surrounding and supporting and shadowing and sheltering those few minutes of chat and pleasantries. While he had skill and insight, what he didn't know was that everything was leading to a sunny day, a tree, a walk in a park, a few predictable niceties of exchange between two men.

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[*] Adrian van Kaam, *The Art of Existential Counselling* Pennsylvania: Dimension Books, 1966, xii.

I went to therapy myself for a number of years. I was a gay lonely man in a place where I was neither holy enough nor heterosexual enough. I wasn't sure who of my friends I could trust to tell a story to, so I paid someone to listen for three years. I think everything is tied up in this poem, called *Narrative Theology No. I.*

> Narrative Theology No. 1
>
> And I said to him
> Are there answers to all of this?
> And he said The answer is in a story
> and the story is being told.
>
> And I said
> But there is so much pain
> And he answered, plainly,
> Pain will happen.
>
> Then I said
> Will I ever find meaning?
> And they said
> You will find meaning
> Where you give meaning.
>
> The answer is in a story
> and the story isn't finished.[11]

Story, too, is a protest against a society that might deny our stories. I was sitting around a table of men once, and a young man around the table said something about the Troubles — the name given to the 30 years of hostilities between 1968-1998 in the north fo Ireland that saw 3500 people dead, and over 100,000 people suffering some physical injury. So the young man had said something about the troubles and an older man — a man with an International Reputation as a Peace Worker — said "You're too young to know about the troubles". And the following story erupted. It's a poem called "Not Yet".

> Not yet
>
> 'You're too young
> to know about
> The Troubles,'
> the peaceman said.

" Pádraig Ó Tuama, *Readings from the Book of Exile*, Canterbury Press, 2012

And the youngman said:

father shot dead mother fell apart
brother fell into himself
other brother sent to live with others
and me in mothered everything
i was formed around
and now years later
we have found ourselves
beneath a shared and
troubled ceiling.

fell apart
others
everything
beneath a shared and
ceiling.

Not yet.

No-one's too young
to know about
The Troubles.[12]

Story is its own protest and when you deny a person's story — I know that you know this — a person's protest is powerful. You may feel the force of it. Or they make make the force of it felt by another person deemed weaker than they, or they may make themselves feel the force of their own story. Whichever way it goes, the force goes powerfully, such is the strength of the need for story to be heard.

I'll finish with another story.

In the 20th Century, Anaïs Nin wrote books. She was an essayist and memoirist born to Cuban parents in France. She wrote essays, literary criticism, erotica and diaries. In a semi autobiographical sequence in *The Seduction of the Minotaur* she uses the phrase "We do not tell stories as they are, we tell stories as we are." [13]In the book she attributes this phrase to the Talmud, commentaries on law and religion in the Jewish faith. However, this phrase is not in the Talmud, although some argue that there is an oral tradition of Talmud in which it does occur. So she made up a story about a phrase that's bigger than the story of her life.

And so, whether by her design, or simply because she was in the way, we have this phrase.

We do not tell stories as they are. We tell stories as we are.

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* Pádraig Ó Tuama, *Sorry for your Troubles*, Canterbury Press, 2013.
* Anaïs Nin, Seduction of the Minotaur (A. Swallow, 1961). Garson O'Toole has recently published a fine exploration of the many possible origins of this phrase on his website (quoteinvestigator.com).

INTRODUCTORY COMMENTS: BALINT THE INTERNATIONALIST

Dr. Esti Rimmer

By the time of his death, on the final day of 1970, Balint was a central figure of the British psychoanalytic establishment. He was the president of the British Psychoanalytic Society, a citizen of the UK, and a Unitarian. He had worked at the world-famous Tavistock Clinic and along with his third wife, Enid, pioneered the work with GPs, social workers and marriage

guidance counsellors, which later came to be known as Balint Groups. His book, *The Doctor, his Patient and Illness,* became a seminal textbook translated into many languages, and he began to make inroads into medical education in the UK and elsewhere.

Yet Balint's beginnings could not have been more different from the genteel, leafy world of Hampstead that he came to inhabit. Balint began life as a Hungarian Jew named Bergman Mihály and later changed both name and religion—against his father's wishes—in order to avoid anti-Semitic restrictions that would have prevent him from pursuing his university studies.

"What's in a name?", asks Shakespeare's Juliet. As we know, however, Juliet's wish to transcend tribal loyalties through the denial of one's name had tragic consequences. Indeed, a name is an important marker of an individual's identity that cannot so easily be renounced. It is a complex symbol of belonging and origin that often evokes mixed feelings because it represents ambivalent attachments and loyalties to family and tribe. Hence, while changing one's name suggests a desire to forge a new beginning and move forward, it also implies a degree of unavoidable loss. I believe that the trauma of migration is important for us to bear in mind and think about at the beginning of our international congress, which is dedicated to questions of identity, diversity and culture within Balint's work.

We are hoping that this session will allow us to further explore Balint's own journey, with the help of archive materials and Raluca's paper and to highlight how his experience of home, exile, loss and trauma, as well as optimism, new beginnings and creativity informed his approach to the doctor patient relationship.

Balint and his first wife Alice were refugees on two occasions: in 1920, they fled to Berlin after the overthrow of Bela Khun's Communist Republic in Hungary led to the closure of the Chair of Psychoanalysis at Budapest University, which was held by Sándor Ferenczi. Like most

Austro-Hungarian subjects at that time, Balint was fluent in German and he was able to resume his work and begin his analysis in his second language. However, after two years, they returned to Budapest where Balint continued to work with Ferenczi, before being exiled a second time in 1938, after the German Anschluss of Austria. This second exile entailed starting to work in a third language and in a very different cultural and social milieu. Moreover, on arrival in the UK, Balint was exiled internally, to Manchester, far from the centre of psychoanalytic thought, in London.

The grim years of the Second World War brought home the traumatic dimension of Balint's migration: Alice died in 1939, followed by the suicide of his parents in in the last months of the war in Budapest, in the face of deportation to Auschwitz. In Balint's appointment diaries, which can be found in the archives, we see a poignant representation of the years of transition, loss and absence. Until 1938, they were written in Hungarian. Then, following a gap of several years, they reappear in English. Interestingly, as Balint attempted to forge his new identity, in his new home, in a new language, with a new name and a new religion, his work nevertheless develops in a direction that brings together the legacies of both lost paternal figures: his biological father the GP, from whom he derives an interest in psychosomatics, and the world of general practice, and his psychoanalytic father Ferenczi, who inspired his interest in the interactive process between doctor and patient.

Balint brought with him a strong tradition of the Hungarian Psychoanalytic School and, in particular, Ferenczi's emphasis on the relation with the other, starting with the mother baby relationship as the paradigm of the early object relationship and moving on to the caring relationship between the doctor and the patient. Ferenczi's influence on Balint's work is to be found in its innovative style and in the emphasis on inter-subjectivity. The method involves curiosity towards the other, as well as the desire to engage in fruitful, creative and collaborative endeavours.

Ferenczi's circle of intellectual friends in the *fin-de-siècle* cafés of Budapest, which included artists, scientists, doctors, writers and psychoanalysts stimulated an exchange of ideas between different disciplines, in a spirit of equality and mutual respect. This legacy is clearly reflected in Balint's ideas and in his work with general practitioners. He did not conceive of his purpose as one of "educating" GPs in psychoanalysis; rather, he considered the interaction to be a mutual learning experience. This idea is also reflected in the ethos of the Balint group, where every contribution has equal value and nobody is seen as an "expert". It informs also his vision of the doctor-patient relationship, as one of joint endeavour.

In Raluca's paper—and the exhibition material—we can see how Balint continued Ferenczi's tradition of interdisciplinary dialogue, through his extensive correspondence with intellectuals of many disciplines. In effect, Balint recreated the Central European café society of the turn of the century in letter form.

Michelle Moreau-Ricaud refers to Balint as a *passeur*: a smuggler, who carried Ferenczi's legacy across borders and into the UK and France. However, the *passeur*, or the one who crosses the border goes in both directions and Balint's ability to transcend limitations also goes both ways. He brings aspects of his inheritance and early experience to the UK, but also takes something from his work in the Tavistock and the creative partnership within it, and transmits it to many other countries. One of my Balint colleagues from Israel once described his attraction to Balint's work by saying that Balint is a home for the homeless professionals, for those who feel they do not exclusively belong to one group, but for those who feel they have a more fluid and flexible identity and feel more comfortable in the liminal experience.

Balint, the cosmopolitan polyglot, was able to transcend the constrained definitions of borders, cultures, nations and exclusive clubs. This is why he was so apt and able to sow seeds in many lands and why we see Balint work flourishing in five continents. All of you here are

testament to this. Yet the paradox is that while we all recognise the universality of the doctor-patient relationship, wherever there is a doctor, a patient, an illness and a consultation, Balint emphasises the particular patient, the particular doctor and their particular relationship. In what follows, we hope to encourage thoughts and debates on the themes I have raised, today and throughout the congress.

ON MICHAEL BALINT'S TRAILS

Raluca Soreanu

Not available online.

Contact author on r.soreanu@bbk.ac.uk

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ARCHIVE PRESENTATION-On display during the Congress

Exhibition Material:

International Connections;

Establishing Self in UK; (Making a new Home);

Conversations with Other Disciplines;

Manchester Research Project;

Correspondence around the First GP Group; Collaborative Work from FDB to GP Group;

Representing Ferenczi's thinking in London;

Correspondence: Anna Freud, Lacan, Tredgold, others…medical establishment;

First Edition Covers of 'The Doctor, His Patient and the Illness' in many different languages

Exhibition Categories (correspondence):

- · Struggles. Exile. Finding a new home.
- · Enculturation. The ways of the new land.
- · Exploring other disciplines. More than medicine and psychoanalysis.
- · The legacy of the Budapest School of psychoanalysis.
- · How the "Balint group" travels worldwide
- · Controversies. Psychoanalysis or not?
- · Warm reviews. Leaving a mark.
- · The difficulty of the craft [Tredgold]
- · Being in dyads [Loch and others]
- · Self-reflection after a long journey ["The Genesis of My Ideas"]

Archivists: Joanne Hanford and Euan O'Neill

ASPECTS OF DIVERSITY – THE DIFFERENT, THE STRANGE, THE DISTANT, THE UNFAMILIAR, AND THE INCOMPREHENSIBLE IN BALINT WORK

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Abstract

Using vignettes from Balint groups, the paper concentrates on what is experienced as strange, threatening, or incomprehensible, and how defense mechanisms are being used to deal with something which diverges from the familiar. If we want to understand the different or the foreign, if we are looking for a context which makes sense, we need to include our own 'foreign' feelings. It means seeing the difference as something valuable, and not as something we need to get rid of.

Paper

In one of his latest books the writer and painter Rabih Alameddine lets his Lebanese heroine Aaliya describe herself: "I'm a conscientious cleaner, you might even say compulsive - the sink is immaculately white, its bronze faucets sparkle – but I rarely remember to wipe the mirror clean. I don't think we need to consult Freud or one of his many minions to know that there is an issue here" (Alameddine, 2015).

If the author were attending a Balint group, would we expect him to present his patient Aaliya to the group? Perhaps he does not feel the need to because he considers the mirror-issue as something so minor, so not out of the ordinary, or so familiar that he does not see the need to consult Balint or one of his many minions.

But what if patient Aaliya is Lebanese, and doctor Rabih comes from another part of the world? Will he be irritated or troubled by a woman and the cultural differences between them, or will he be struggling with prejudice, or with the fact that Aaliya has had to live through two wars in Lebanon? So let's assume doctor Rabih is keen to talk about himself and his patient in a Balint group for the same reasons we go there - because we want to explore the diversity, because we want to *understand* something new. In this respect we have the same motives as John Cassavetes, the wonderful filmmaker, who is quoted saying: "Why would I want to make a movie about something I already understand?" (Cassavetes, 1994).

But let's go back to our topic and ask: what is diversity anyway? It implies differences, greater variety, or contrast. It is about issues that can irritate, upset or frighten us. And most important, what is embodied in it is the concept of sameness – they are like dialectical twins in the philosophical sense: if we become aware of diversity, we cannot avoid realizing that something is happening to our feeling of sameness. If we talk about 'the other ones', if we talk about 'them', we also have to talk about 'us'. It is not a one-way street. We can perceive someone as the foreigner, the stranger, the other, but in all likelihood we are also strangers to him or her. So we have to deal with not only the feelings of others, of 'foreigners', but also with our own 'foreign' feelings.

In our work with patients this confronts us with some questions. Is diversity something that draws or pulls us towards it, interests us, strains or stimulates us? Or do we try to keep our distance? And can we accept difference – or better even: multiple differences – without feeling the need to align, to approximate?

Our approaches or our detachments are closely related to our receptors: What are we receptive to in our interactions? And when do we - does our countertransference - block our receptors? This can be triggered by a number of things in a patient - behavior aspects, cultural backgrounds, frightening experiences and traumas, issues of sexuality and gender identity, class differences, psychiatric disorders, or political opinions, which might make us feel uncomfortable or uneasy with a specific patient, and we might feel even more reluctant to present our 'case', meaning ourselves, to the group. We feel thrown into the unfamiliar, and challenged in our comfort zone. We know we will not get away with protecting ourselves, we know we will be asked the inevitable question by the ones whom we consider 'strangers', a question best expressed with words by Luce Irigaray, French culture theorist and psychoanalyst: "But I, am I not a reminder of what you buried in oblivion to build your world?" (Irigaray, 1992).

When something becomes unbearable - is creating an inner distance easily visible?

The presenter introduces the group to a female patient whom she has been seeing for some months now in her GP practice. With her partner, the patient has 3 kids, but when the eldest daughter went away to college, the patient soon found herself in premature menopause and developed psychosomatic symptoms, mostly breathing problems and nightmares involving the daughter's wellbeing. The presenter feels sorry for her patient and is puzzled as to why the symptoms keep coming back although there are no pathological findings.

The whole group seems to be impressed, and almost comfortably settles into an alarming contentment with thoughts like, "looks nice and smooth". It seems easy to understand the presenter's and the patient's relationship, almost too beautiful a picture. For a while they dwell on phantasies about the various symptoms of menopause and the patient's sadness because of the daughter having moved out.

But let us be careful as facilitators. Before we are too easily satisfied, let us remember that the philosopher Francis Bacon left us a warning from way back in the 17th century in his essay "Of Beauty" . He tells us, "there is no excellent beauty that hath not some strangeness in the proportion" (Bacon, 1612).

So, what is hidden behind this readiness to be so homogeneous, so in unison? Is it reluctance or resistance to see the ragged edges, the spikey corners? Half way into the process, however, the group begins to assume that the patient offers the doctor some minor, less frightening reasons for her symptoms, although they may well be seen as a signpost pointing back to an underlying trauma. When the presenter is asked back in she says how the group discussion made her aware that during her introduction it did not cross her mind to mention that the patient had been the victim of rape by her stepfather's brother when she was her daughter's age. The presenter admitted that she had completely brushed this information aside because the mere thought of this abuse felt frightening and extremely repugnant, and the patient's daughter and her own are the same age. Also, the patient has told her that

the offender had apologized to her, and seeing him at family gatherings is now ok for her, or so she claims. Thus the doctor decided that concentrating on the presented menopausal changes would be more important and helpful for the patient than something long gone.

We may conclude that using this rationalization acts as a defense mechanism which helps to maintain an inner distance. And as is the case more often than not, the hidden, the repressed, the frightening, or the denied seeped into the group process.

Strangeness, strange words and their explosive spark

The young doctor in her foundation year presents the case of a Romni, a refugee who had left her country of origin with her family after hate crimes against Roma people. The family's house was burnt down, one of her grandchildren died in the attack. Because of acute appendicitis she was admitted to the hospital for the operation.
The patient's first language is Romani, but she knows some of the language of the country of resettlement, just enough to get by. Being in a hospital for the first time in her life, she appears disoriented and easily irritated. On two or three occasions she asks the nurses for something to which she adds: "I eat your heart". They read it as a threat: "You better bring me what I asked for, or else…". They become fearful, all prejudice against Roma people flares up, the senior doctor in charge is called, he prescribes strong tranquilizers and anxiolytics.

The doctor in training feels helpless in her position in the hospital hierarchy, she is irritated by the patient's words, and unsure whether she should identify with the young nurses' fear. She has a feeling, which she cannot explain, that there might be another reason for the patient's behavior, like the repetition of a trauma, or perhaps deep down she is just a demanding person used to threatening people. So she takes her irritation to the group.

In Balint groups we are giving space to whatever comes to mind. This might appear at times like generating non sequiturs, unconnected elements, but only seemingly so. There is always the unconscious undercurrent, for which we have to allow time, give time. Things can not be hurried, just as a Chinese saying goes: "You cannot push the river".

This can place a demand, but also questions or doubts on group leaders, sometimes even a dilemma. And as the group facilitator in this case I already find myself in one. Working for a Roma organization in Vienna I have learned some Romani, and I understand the patient's sentence: "I eat your heart". If translated back into her language, it is a way of saying 'please' in a special endearing way to younger people, like to grandchildren. It can be compared to "please, be so kind, I love you a lot", or "be a darling, please". Saying this, though, is the prerogative of someone older; young people are not to address older people in this way. Here, like in many other cases, I regret the lack of hospital translators with their ability to also introduce ethnic characteristics (Tribe & Morrisey, 2004).

So what do I do now with this knowledge? Shall I tell the group right away? Or do I hear their clarifying questions first, or even let them start their group work? And if so, at which point do I come forward with my information? I decided to wait in order not to block their thoughts and especially not their emotions. For quite some time these concentrated on the patient. A group member's first shy remark about not understanding the phrase in question was overrun by strong words, ranging from anger, to the strongly felt need to protect oneself from the assumed aggressive attitude, to honestly admitted prejudice. The elephant in the room had 'stranger',

'fear', and 'unfamiliar' written all over him. When the heated discussion became calmer I felt confident enough to ask the group if understanding the patient's phrase would help lessen concerns, and I told them about the translation. This enabled a shift in the way of looking at the situation of both the doctor and the patient, and it increased the understanding of how quickly the incomprehensible is rejected, especially when it is linked to a discriminated minority.

Passed over in silence: The issue of class differences

On a very general basis, important issues like social equality or the access to education for everyone are widely acknowledged. On the basis of personal interactions between individuals in clinical or psychotherapeutic settings, however, the fact of class differences "is not so much excluded ... as elided and disavowed. That is to say, it is there, but not there" (Ryan, 2009). This does not apply to psychotherapy only, an issue which Joanna Ryan, a London psychoanalyst and supervisor, has concentrated on in her research. It is established just the same as a widespread taboo in a liberal society and its egalitarian ideals in which it is considered not p.c., not politically correct for us to look into the topic because wishful thinking leads us to believe that there is no such thing as class anymore.

This problem of eliding and excluding class related topics inevitably has its effects on the process of transference and countertransference (Ryan, 2006) for psychotherapists, clinicians, and in Balint groups.

Let's take therapist A: His own background is middle class. His patient is working class and doing well in his road works job but has a problem with containing his aggression; he feels easily provoked and tries to show his superiority by starting physical fights in bars. The therapist knows that the patient's father was not able to hold a steady job, and the mother's income was not enough so the family was quite poor. The income is not the only difference; the therapist also knows that there are issues here of diverse class histories, only he does not know how to include them in the sessions out of guilt about his inherited privileges and pride in his achievements. In his countertransference he feels vulnerable and fearful of the patient's accusations and readiness to compete.

Will he bring his dilemma to the group or avoid it? He might express his uneasiness with aggression issues, but can he talk about his guilt, or his pride? Perhaps he will hesitate out of fear of being labeled arrogant, or out of embarrassment if his conceit or his need to justify himself is found out.

And what about doctor B: She comes from a working class background, and although she has worked hard enough to complete her academic training, she still experiences fear of inadequacy. Her middle class patient flaunts expensive designer products and tells her she sounds a little working class. In her countertransference she rather quickly feels the patient is frequently complaining without reason, just as the spoiled child which the doctor assumes the patient used to be – which of course is only an assumption.

In the group she might talk about her anger and perhaps her envy, but can she admit how difficult it has been all her life to deal with her own painfully felt conviction of not being good enough, and feeling ashamed?

How will it be for both A and B in a Balint group? Very probably some group members or leaders have the same class background, one or the other, but will *they* understand, or feel like exposing themselves by paying attention to, or want to even look at the issue?

It is always like walking a fine line to pick up on such delicate social aspects when only rarely has there been a good enough framework for including class issues in the respective previous professional trainings. Nonetheless, the social stratum is charged with diversity, including diverse class backgrounds. Not going further means avoiding looking at the additional issues, like the pain of inequality or the guilt about privilege (Ryan, 2006).

If we acknowledge that class is not 'out there', but is part of ourselves, it will allow us to use the plenitude of experiences of patients, doctors, and psychotherapists (Ryan, 2009).

Conclusion

So at the end now we are back where I began: we attend Balint groups because we want to understand more. Being confronted with an experience that diverges from the familiar, we are not automatically open to the unfamiliar. Defense mechanisms do of course not only happen in Balint groups, we witness them in everyday life. If we feel a lack of safety, a lack of control, displacement happens, a shift from what appears threatening onto something else. Our defenses are looking for an object we can exert control on. The psyche might feel helpless when the banks crash, therefore it tries to make up for it by demanding punishment for the Syrian woman who wears a burkini, or for the Afghani refugee boy who steals a pack of chewing gum.

If we want to understand the not-so-well-known, if we are looking for a context which makes sense, we need to include our own 'foreign' feelings. It means seeing difference as something valuable, and not as something we need to get rid of.
In her book "Strangers to Ourselves" Julia Kristeva, Bulgarian-French linguist and psychoanalyst, states that it is all about discovering and analyzing our own disturbing otherness, "for that indeed is what bursts in to confront that 'demon', that threat, that apprehension generated by the projective apparition of the other at the heart of what we persist in maintaining as a proper, solid 'us'. By recognizing *our* uncanny strangeness we shall neither suffer from it nor enjoy it from the outside. The foreigner is within me, hence we are all foreigners. … To worry or smile, such is the choice when we are assailed by the strange; our decision depends on how familiar we are with our ghosts" (Kristeva, 1991).

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CROSSING BORDERS-LAYING THE LANDSCAPE OF BALINT IN PAKISTAN

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Abstract

The Balint intervention helps in strengthening the clinician-patient relationship by broadening the clinician's insight into their counter-transference. The applicability of Balint technique in diverse cultures like Pakistan needs qualitative and quantitative research. At Aga Khan University Hospital in Pakistan we took the initiative of setting up such a Balint group for nursing staff working closely with patients receiving cancer and palliative treatment. Our Balint group's diversity has multiple facets due to the complex socio-cultural and spiritual fabric of the Pakistani society within which this group operates. Cultural transference towards the Balint leader, expression of spirituality in the counter-transference and the risk of pseudo-countertransference are explored in this paper. The paper also deals with the challenges leaders/facilitators may experience when setting up such groups in diverse cultures like Pakistan where freedom to think and speak is not always culturally sanctioned.

Keywords: Balint group, counter-transference, culture, Pakistan.

Introduction

Balint groups focus on exploring the doctor patient relationship. Reflecting on one's countertransference and facing emotional challenges experienced during clinical encounters requires a space where clinicians feel safe, contained and held (Balint, 1964; Johnson, 2001; Adler, 2002). This space is both a physical and psychological territory where clinicians come to terms with uncertainty, tolerating differences and owning otherwise disowned mixed feelings. In the absence of such a space it becomes difficult to weave the fabric of psychological insight using the thread of counter-transference. In this paper we wish to explore some of the socio-cultural challenges that we encountered while establishing such a space in a diverse society like Pakistan. Understanding these challenges provides insight into the socio-cultural variables that need considerate attention before setting up such groups in a multilingual and culturally diverse country like Pakistan.

Historical and geographical perspective

Pakistan is the sixth-most populous country in the world with a population exceeding 200 million. Geographically Pakistan is strategically placed at the interface of Middle-east,

central and South-Asia and shares borders with China, India, Afghanistan and Iran. The social fabric of Pakistan therefore has an interesting mix of Persian, Arabic, Indian and Afghani influence. Pakistan was created in 1947 as an independent Muslim country following separation from the British Empire. A civil war in 1971 led to the separation of East Pakistan and creation of Bangladesh. Pakistan is ethnically and linguistically a diverse country. Islam is the predominant religion and religious minorities consist mainly of Hindus, Christians, Sikhs, Zoroastrians and Buddhists. More than 60 languages are spoken in Pakistan including a number of provincial languages but Urdu and English are the official languages (Minority Rights Group International, 2010). Although Urdu is the primary language of communication English remains the language of choice for educational, legal and business purposes.

Psycho-oncology Balint group at a tertiary care hospital in Pakistan

Aga Khan University hospital is a tertiary care, private hospital located in the city of Karachi, Pakistan. Over the years this hospital has developed an international reputation for being the centre of clinical and academic excellence. In order to bridge the gap between the medical and psychological needs of patients with cancer, Psych-oncology services were set up in 2016 at Aga Khan Hospital. As an extension of this development, hospital management requested us to start a psychiatrist led reflective group for oncology nursing staff. Management reported an increased burnout rate and stress in their nursing staff who they felt were getting into complex dynamics with dying patients. We decided to pilot a Balint group case based discussion model focusing on exploring the counter-transference and the emotional exchange between the nurse and their patients. A series of four induction sessions was arranged. Information relating to the basic concept and framework of Balint group was provided to the participants initially. This Balint group has eight nursing health care staff, who meet once every fortnight for an hour at a designated area of Oncology department. The group is led by MSK and facilitated by AS who is a psychiatric registrar at the Department of Psychiatry. This is the first Balint group to our knowledge that has ever been piloted in Pakistan. The setting i.e. Psycho-oncology and its membership comprising of nursing staff contributes further to the diversity and novelty of this group. We are now going to highlight some of the socio-cultural and dynamic challenges that we have encountered whilst setting up and running this Balint group in Pakistan.

The interplay between Balint framework, social and cultural

The use of hybrid language for emotional reflection

People in the urban areas of Pakistan are now increasingly using a hybrid language that combines Urdu and English vocabularies for ease of communication. The hybrid technique helps in bridging the linguistic gap between the two languages. The nurses in our Balint group preferred using the same hybrid language for communicating their feelings i.e. neither Urdu nor English alone but a combination of both. We observed that the nurses selectively preferred English when reporting mixed feelings/affect (e.g. disgust, despair, annoyance or shame) but relied more on Urdu for primary emotions, primitive feelings and spiritual distress. When Urdu was used deliberately to translate complex mixed feelings the narrative of the group sounded too poetic and rather artificial. The group's ability to be "inter-lingual" created a diverse narrative in which intra-psychic and interpersonal vulnerability was expressed using both foreign (English) and native (Urdu) vocabulary. Linguistically, this may just be because of the strong historical influence of English over Urdu dating back to the British colonial empire. But from a dynamic perspective it shows how the process of

translation of complex feelings sometimes can subject feelings to unnecessary censorship so much so that they may eventually lose their true identity. By no means was this just a struggle for the nurses in the group but for us too as my (MSK) previous experience has always been of Balint groups where English was the sole and primary language of communication. As a leader/facilitator we realised that having flexibility in the use of language helped in creating that experimental ground where staff can safely explore and communicate their emotional states in the language that best represented their internal affect.

Submission to authority and pathological obedience

Submissiveness towards authority is seen as a sign of devotion and respect in Pakistan. Questioning or challenging such a figure can be culturally perceived as a rebellious behaviour. Submissiveness to supreme power is further endorsed by Islam which preaches absolute surrender to the creator. If unchecked, extreme submissiveness can affect one's capacity to think freely, independently or critically and can create a state of pathological obedience. It is important to understand how this cultural submissiveness can interfere with the Balint matrix as the task of exploring one's counter-transference requires rebelling against traditional ways of thinking or being "curious." Group members may develop a peculiar cultural transference towards the leader/facilitator whose task they see is to encourage freedom of thought. Members might initially view "free thinking" as culturally forbidden as if there might be something quite blasphemous about being curious. The theological perspective becomes important to hold in mind here (Moazam, 2000), based on which Prophet Adam got expelled from the heavens because he dared to think and act differently to what he was instructed by God. Adam's descent from the heavens to Earth is therefore seen as a divine punishment, the fear of which still hibernates in the society at large. Such paranoid anxieties relating to being "singled out and exiled" can be projected into the Balint leader too when he/she attempts to encourage freedom of thoughts and speech. It is therefore important that the Balint leader understands these cultural limitations as he/she could be perceived in the transference as a spiritual, religious or tribal leader who is expected to adhere to a traditional or divine script. The leader's wish to create a free thinking space could be perceived by the group as a liberty too much to digest. They may equate this granted freedom as something quite forbidden and try to maintain a silence of pathological obedience. In order to develop separateness from the cultural submissiveness, a closed rather than an open Balint group works better in a setting like Pakistan. This is because shame and doubt may precede or follow healthy curiosity and a closed Balint group offers a safer setting where members can explore their genuine counter-transference without feeling overwhelmed by either the fear of divine punishment or cultural exile.

Divisive splits in the society and its impact on Balint

Pakistan is an economically developing country which is moving on to become a progressive and democratic society after years of rule under different dictatorships. There remain multiple divisions within the society based on gender, class, caste, religion and political affiliations. The patriarchal nature of the society, lack of social integration between religious sects and knife sharp class divides have created an atmosphere of social paranoia with a fear of disintegration by the more powerful. This fear has possibly heightened following the geo-political changes post 9/11 and the subsequent impact of terrorism on the psychological landscape of Pakistani society. Because terrorism silences freedom of speech and attacks differences in a hope to achieve pathological sameness, the society has become split into multiple islands of paranoid schizoid communities. The "vulnerable self" of these

communities remain socially quarantined and hidden from each other due to fear of being consumed by the more powerful. Expression of one's vulnerable self can be very challenging in such an atmosphere as it requires laying down one's defences which is culturally seen as a sign of weakness rather than strength. Understanding these social splits is important as it helps to comprehend the challenges one might face when assembling a heterogeneous Balint group in a divisive society like Pakistan. When doctors/clinicians belonging to different communities, classes and sects are aggregated in a group, the purpose of which is to reflect on feelings, lay down their defences and own their vulnerability, then Balint could become a social experimental playground. Although the task of Balint will never steer away from understanding the clinician patient dyad but indirectly this experimental space also provides the opportunity for social integration and marriage of emotional differences.

Power hierarchies

In our Balint group the majority of the members are females with only three men. The preference of male members to sit next to each other reflects the underlying cultural anxiety that they might either get singled out or their masculinity might come under attack by engaging in a process of emotional reflection (West and Zimmerman, 1983). Women are quite often expected in the group to take the lead in disclosing feelings and they often become the voice for other male members who struggle to own or disclose their vulnerability when dealing with dying patients. The leader/facilitator should keep a check on this as otherwise there is a risk of patriarchal divisiveness within Balint. It is our view that in a country like Pakistan it helps if the co-facilitation for Balint groups is undertaken with the opposite gender. This helps in setting up a dynamic of co-dependence between the male and female facilitators. The group views this as a non -traditional yet symbiotic relationship where roles and power can be shared between opposite genders without necessarily losing one's identity. Our Balint is also peculiar as there is another power imbalance between the nurses (members) and the doctors (leader/facilitator). Historically the power struggles of doctor nurse relationships date back to the times of Florence Nightingale (Greenfield, 1999) and can resonate within Balint too. As a leader/facilitator we were mindful of this challenge and have tried to promote a democratic and shared ownership of the Balint within the members in order to try and dissolve such power splits.

The risk of pseudo-countertransference

The anxiety in relation to exploring one's counter-transference is perhaps universal but in a society like Pakistan this anxiety can sometimes have a phobic quality. This is due to the profound cultural dissonance that clinicians may experience when exploring their genuine feelings towards patients. The class and religious divisiveness between clinicians can heighten the fear of being socially or morally judged by others. This creates a space for pseudo-countertransference i.e. clinician's feelings towards patients that are either thoroughly intellectualised, rationalised or perhaps not genuine. An example of this can be the range of counter-transference which nursing staff may experience towards a patient who engages in social drinking or has a liberal take on pre-marital sex both of which are punishable offences in an Islamic country like Pakistan. The liberals or clinicians from a relatively higher socio-economic background may have a very different approach dealing with their feelings compared to those from a more traditional background. Metabolising a range of complex countertransference, helping the clinicians use this as a tool to broaden insight and enabling them to own their socio-cultural bias requires sensitive handling of information by the Balint leader/facilitator. It is imperative that the group should never lose sight of the patient as a

HUMAN whose interaction with another human (i.e. clinician) should be analysed unbiased by class, caste, moral or other differences.

Death anxiety and spirituality in the Balint group

The nursing staff in our Balint group work closely with people diagnosed with cancer some of whom eventually receive end of life care. Staff very often discuss cases (including children) where death and dying come up as existential questions. Identification with one's own mortality, fear of uncertainty and becoming non-existent are some of the many anxieties which surface in their counter-transference. Quite often the staff locate such vulnerable feelings entirely in the patients or their families with relative disconnection from their own vulnerability as clinicians and humans. In this context it is important to understand the significance of spirituality in a culture like Pakistan where life and death are treated as spiritual transitions. It is not uncommon in Pakistan for God to become a focus of clinical discussion between the clinician and patient to provide hope and alleviate despair, especially when breaking bad news. This triangular relationship between the clinician, patient and God can replicate itself in the form of a spiritual counter-transference within the Balint group. The simple act of praying for a patient in the group somehow enables a group in mourning to engage in a mystical catharsis which helps them overcome their own fear of death and dying. Spirituality, we believe, provides a license for psychological catharsis in Pakistan using which even the most defended clinicians are able to lays down their defences and own their vulnerability.

Conclusion

Balint, like any clinical group, is a micro-fraction of the society at large in which it operates. It is therefore important to understand the social, cultural and spiritual fabric of the society in which it is dynamically administered. Socio-cultural variables can resonate within the matrix of Balint and can influence the technique with which it is executed or navigated through. Our Balint group is novel in certain aspects as it involves nurses (rather than doctors) providing cancer care to patients some of whom are receiving end of life care. The fact that this Balint group is led by two doctors adds a further interesting dimension due to the hierarchal differences between doctors and nurses historically. Ongoing qualitative and quantitative research is imperative to understand how socio-cultural variables interplay with the Balint technique and contribute to enriching its framework in diverse ways.

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WISE AND NOT SO WISE REASONING. A BALINT GROUP PROJECT FOR ANAESTHETISTS AT A STOCKHOLM HOSPITAL

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Abstract

Wise and not so wise reasoning. A Balint group project for anaesthetists at a Stockholm hospital

Background

Work environment problems initiated a project for the anaesthetists. An evaluation was asked for.

Methods

A web-based questionnaire measuring experienced work environment before and after the one-year intervention.

A focus group interview with six of the 36 participating doctors.

Results

The work environment had improved concerning openness and discussion climate at the department.

Dramatic emergencies, uncertainty and conflicts were the topics mostly discussed. The doctors appreciated talking about difficult things with peers. The group work could break hierarchy barriers, and facilitate self-knowledge. The investment by the department was an important signal. The leader was able to change his style somewhat according to the needs of the anaesthetists.

Conclusion

As in other hospital Balint groups, there was more focus on emergencies, and the work of the leader was a little different from in the traditional groups. Anaesthetists need and can participate in Balint work if supported by the management.

For full text contact the authors

Balint group work as a serendipity

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Abstract

Balint group work as a serendipity

Henry Jablonski

Keywords: Hospital doctors, Balint work, professional threats and insecurity, clinical uncertainty, professional development and creativity, serendipity

Background: Initiating Balint group work at the Department of Anesthesiology and Intensive Care at a Stockholm Hospital

Aims: Joining a Balint group program to help doctors dealing with increasing work load, emergencies, medical disasters, dying patients and relations to the relatives of dying patients, managing professional uncertainty; improve quality and safety

Method: Accounting for the impressions in the preparatory meetings and reflecting on the meaning of those incidences. These are named *serendipities*

Results: Making sense of the interactions preceding group work. Preliminary ideas about the threats and traumas for these hospital doctors and the saluto-genetic processes set in motion at the Department accounted for in continued work and follow–up studies.

For full text contact the author

BALINT GROUPS AS A METHOD OF PREVENTION OF PROFESSIONAL STRESS IN MID-LEVEL MENTAL HEALTH WORKERS

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Abstract

The article focuses on the analysis and correction of professional burnout in mid-level health workers of No. 3 V. A. Gilyarovsky Psychiatric Hospital, Moscow Healthcare Department. The article reviews indicators of professional deformation*and describes Balint group work as a method of prevention of professional burnout. The article cites statistically important results demonstrating a decrease in professional distress in mid-level healthcare workers who attended Balint groups.

Keywords: professional burnout, Balint groups, mental health nurses, distress.

The professional activity of healthcare workers participating in the treatment and rehabilitation of patients entails a high level of responsibility for their life and health, often requiring urgent decisions, ability to retain competency and maximum productivity under extreme emotional pressure. At the same time, it is important to be able to gain the patients' and their relatives' trust, show kindness, and demonstrate essentially psychotherapeutic skills, since mental health patients usually undergo lengthy treatment and need special attitudes and understanding as necessary components of therapy (Zuykova et al, 2016; ibid, 2013).

All of this puts doctors and nurses at risk of professional burnout which, as a type of a professional deformation negatively affects a person's mental health, professional performance and relationships.

For the last 20 years, the issue of professional burnout has been extensively discussed worldwide; however, in our country the issue hasn't been given proper attention. In medicine, the issue is viewed through the prism of work with people suffering from health disorders of different aetiology. Studies have been conducted, involving surgical and ambulance personnel, palliative and disabled children's care workers.

At present, emotional burnout in doctors and nurses, especially those in mental healthcare, is actively discussed at various forums, conferences and congresses. And for a good reason: statistical data points to a high level of dissatisfaction with professional achievements among mental health care workers, manifestations of depersonalization, decrease in emphatic ability. Researchers name dealing with psychologically difficult patients as a contributory factor in the emotional burnout syndrome in doctors and nurses. These are, first of all, patients with low motivation for treatment, those resistant to therapy or those with a poor prognosis, which is often the case in psychiatry and narcology[**]

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*Professional deformation is defined as pronounced changes in one's mental functions and personality caused by professional activity.

**Study of the manifestations of chronic alcoholism, drug and substance abuse and methods of their prevention and treatment.

(Zuykova et al, 2016; ibid 2013; ibid 2014). Research shows, for instance, that when working with cancer patients, 96% of nurses present with different stages of emotional burnout syndrome; every second nurse manifests "a reduction of professional duties" (67%) which demonstrates the effect of the emotional burnout syndrome on the decrease in the quality of nursing assistance (Kasimovskaya, 2008).

An overview of work shows that the issue of emotional burnout in mental health nurses hasn't received enough coverage while it's mainly the mid-level healthcare personnel who work with patients, and, consequently, are in the high-risk group. However, G. N. Uvarova's (2012) work shows mental health nurses to be less subject to professional deformation than surgical nurses. In psychiatric practice, special importance is assigned to closely observing the patient (lest he harms himself or those around him) and adhering to a sanitary regimen. The nurse must be able to spot verbal and non-verbal signs indicating the patient's condition, as well as register changes in the latter's emotional state. E. Y. Lazoreva and E. L. Nikolaeva's work (2013) shows a correlation between the extent of the professional burnout and years of work in a mental clinic. According to the authors, a group with under 10 years of work experience was more subject to emotional depletion and depersonalization, manifesting loss of interest for their work, rudeness in dealing with patients and cynicism. At the same time, nurses with over 10 years of work experience showed a decrease in the emotional burnout characteristics as well as a growing sense of professional incompetency.

The work by I. V. Arlukevich (2013), drawing on research held at No. 1 N. A. Alekseev Psychiatric Hospital, Moscow Healthcare Department, shows that the professional burnout syndrome is formed over a long period of time and is especially pronounced in nurses with significant work experience (20-30 years). At that age, a specialist has enough experience to perform his/her professional duties; however, the experience gained coincides in time with bodily readjustments and apprehensions over one's pre-retirement age.

Thus, to retain professional health while working in the psychiatry sector, preventive measures should be taken at every stage of the professional journey, requiring professional diagnosis and selection, professional forecast and monitoring, professional correction and support of healthcare workers, as well as timely prophylactic and rehabilitation of professional disorders. Balint groups are a traditional, internationally recognized and modern method of overcoming professional burnout in healthcare workers. At the same time, in our county it's less popular and generally accepted than, for instance, one-off trainings; at times, like anything new, it causes explicit or implicit resistance. Nevertheless, the further described experience confirms the necessity of broader expansion of Balint groups in the national healthcare sector.

In September 2015, with the assistance and participation of N. L. Zuykova (Head of the Chair of Psychiatry, Psychotherapy and Psychosomatic Pathology, Peoples' Friendship University of Russia; certified European transactional analyst, Practical Psychology University Professor), under the aegis of the All Russian Professional Psychotherapeutic League (PPL) a major project was launched at No. 3 V. A. Gilyarovsky Psychiatric Hospital, Moscow Healthcare Department. We started Balint groups with nurses on a volunteer basis, with head doctor of the hospital, MD, Professor G. P. Kostyuk offering us great assistance.

Participating in the work headed by A. A. Avagimyan were also co-leaders – Balint group leader Elena Leiko and training programme graduates Diana Sarkisova and Marina Matrokhina.

Materials and methods of the study. Conducted at No. 3 V. A. Gilyarovsky Psychiatric Hospital, the study was performed in several stages, in the form of an experiment. A group of nurses (n=300) was formed at the first stage and the pilot study was held; a 3-day Balint group presentation was conducted. The results were assessed in accordance with the method of field observation. A selection was further carried out to form two comparative groups, with the position occupied as a

criterion for the selection. As a result, two groups of senior nurses who were aware of Balint groups were formed and eight groups of mental health nurses who were unaware of Balint groups. A total of 10 groups were formed, each containing 13-15 members, with representative samples for quantity and quality. Each participant attended no less than 13 Balint groups.

The study included over 90 people, with a median age of 45 and median work experience of 22.5 years. Women made up 95% of study participants.

Methods of the study. Before commencing the work, the Balint group participants were given questionnaires to determine the level of their professional distress. (Work Attitude and Professional "Burnout" by V. A. Vinokur; A Test on the Meaning of Life and Attitude Toward Life by D. A. Leontyev; Zung Self-Rating Depression Scale adapted by T. A. Balashova; L. I. Vassermann Social Frustration Level Diagnostics Method modified by V. V. Boyko). Later, on completion of the course, repeat assessment was conducted to monitor the dynamics of the results of the initial tests. 1.5-hour-long Balint groups were held twice a month.

Results and conclusions of the study: According to our research, nurses assessed their level of social frustration as insignificant or medium. Increased level of frustration was caused by questions on financial situation (8), social situation (13), satisfaction with the service sector (15) and medical service sector (16); the lowest level of frustration was caused by the questions on relationship with colleagues (2), friends (14) and vacation possibilities (18) (see Figure 1).
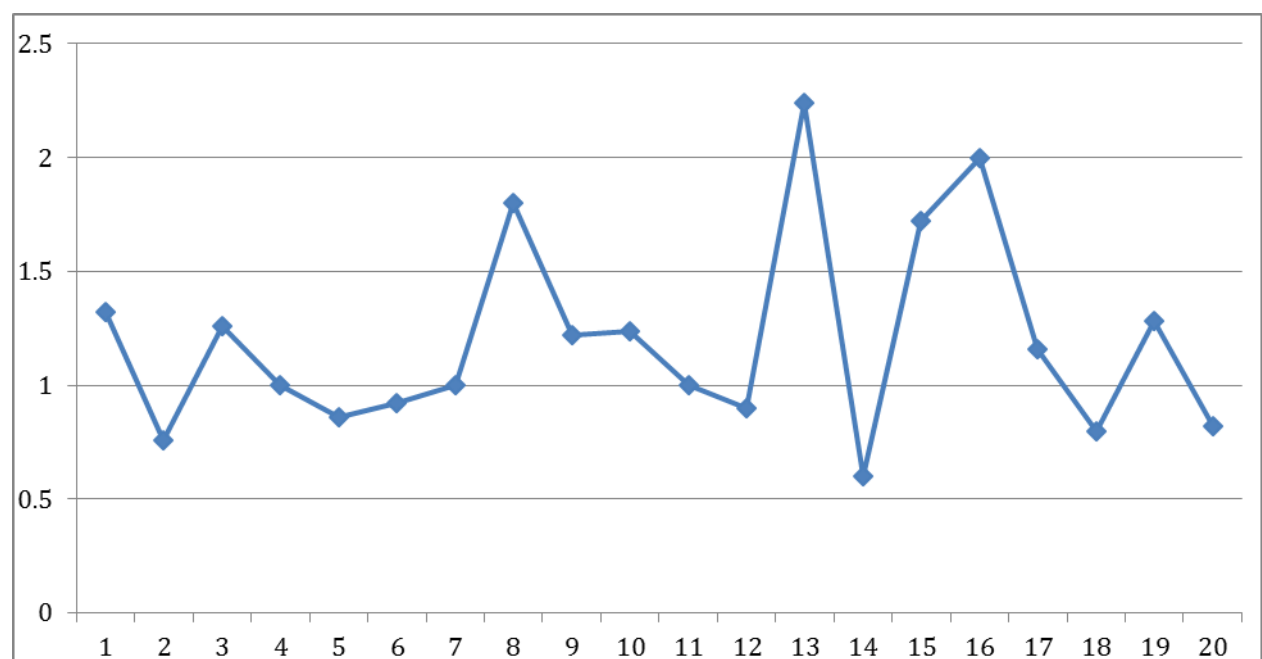
Figure 1. L. I. Vassermann Social Frustration Level Diagnostics Method modified by V. V. Boyko)

I'm satisfied with:

1. My education.

2. Relationships with colleagues.

3. Relationships with management.

4. . Relationships with subjects of my professional activity.

5. My work as a whole.

10. Relationships with my spouse.

11. Relationships with my child (children).

12. Relationships with my parent.

13. Social situation (situation in the country).

14. Relationships with friends, close acquaintances).

15. Sector of services and consumer services.

6. Working conditions.

7. My situation in the society.

8. Financial situation.

9. Living conditions.

16. Medical service sector.

17. Leisure activities.

18. Vacation possibilities.

19. Work choice possibilities.

20. My mode of life as a whole.

Zung Self-Rating Depression Scale tests pointed to the absence of depression, as none of those questioned showed even as low levels of depression as 50 points – slight depression of situational or neurotic genesis (see Figure 2). The under 30 age group showed the most decrease in this respect (4.5 points), which was to be expected as young people are less psychologically stable; after Balint group sessions, the group showed decrease in their levels of anxiety and distress, which coincides with the results of the previous research (Ruzhenskaya, 2013) [10]. At the same time, we need to remember that the Zung Scale assesses subjective indicators, i.e. the level of depression according to the referent (similar to the level of social frustration on the Vasserman scale).
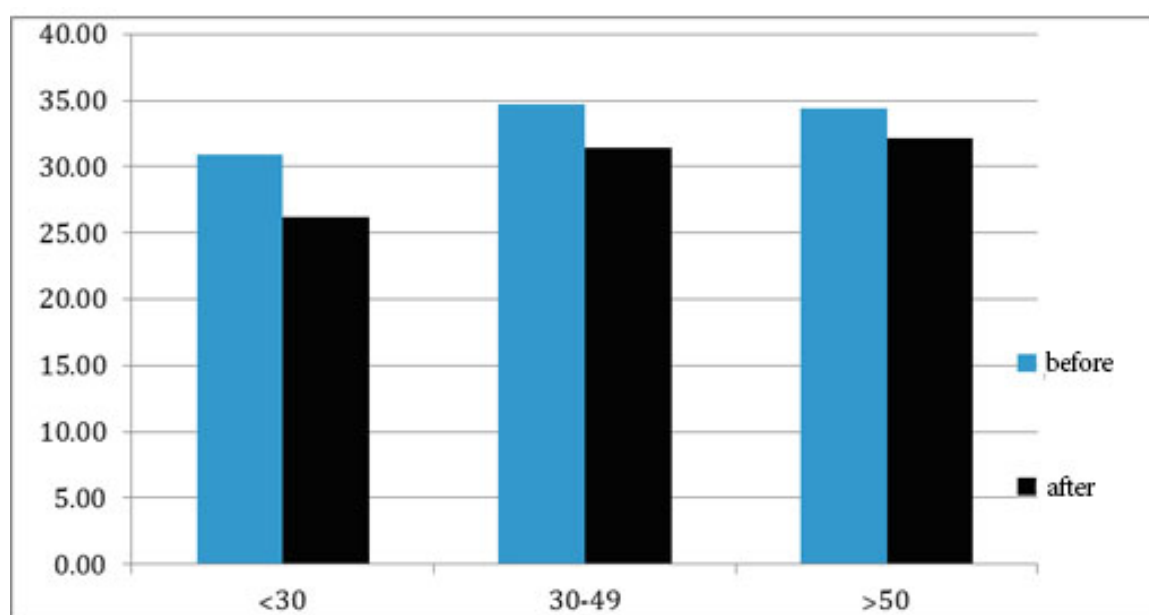
Figure 2. Zung Self-Rating Depression Scale

The Test on the Meaning of Life and Attitude Toward Life showed that nurses have a high level of consciousness of their meaning of life; the results were on the whole comparable to those obtained by E. A. Petrova (Petrova et al, 2011) and A. A. Shestakov (2002)[12] in the assessment of bank workers. It may be noted that after Balint group sessions, the third subscale showed a tendency for increased value (life effectiveness).
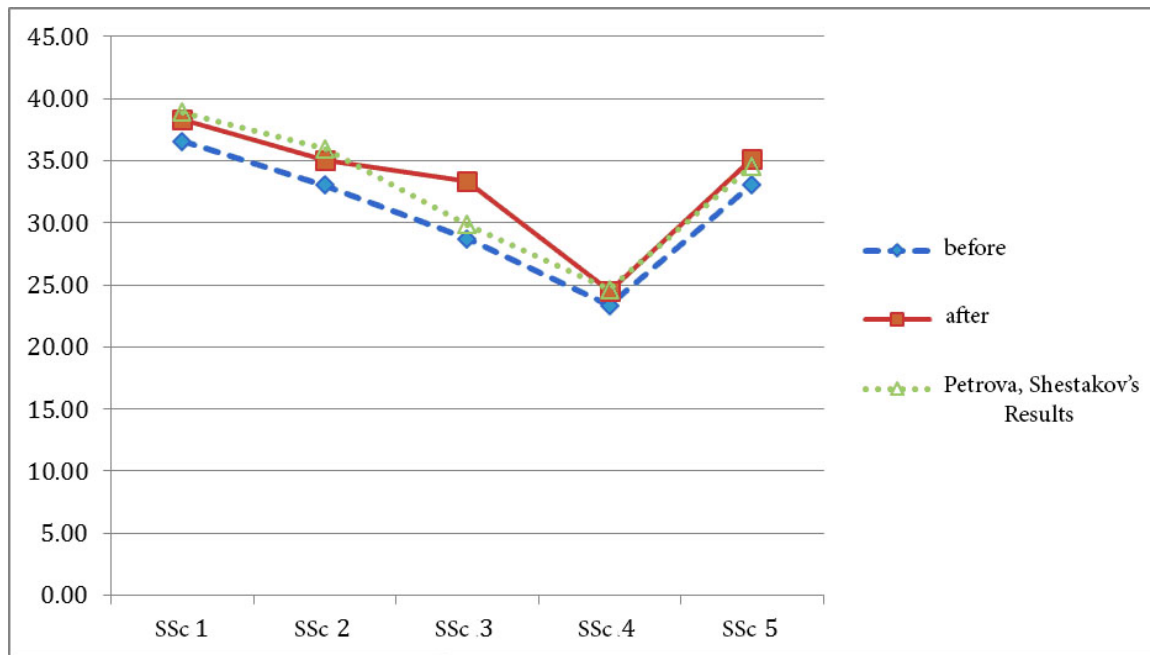
Figure 3. Test on the Meaning of Life and Attitude Toward Life by D. A. Leontyev

Subscale 1 – life meaning, Subscale 2 – life process, Subscale 3 – life results, Subscale 4 – Myself as locus of control, Subscale 5 – life as locus of control

The method of assessment of professional burnout in specialists of helping professions was suggested by Vinokur in 2012 (Vinokur et al, 2012). As shown by our research, this is a powerful tool in diagnosing professional burnout. When compared to the results obtained by the authors of the method during approbation, our results were lower (except Scale 4 – professional perfectionism), yet comparable with the results obtained by Vinokur (with psychologists as a sample group). This is explained by the similarity of the two groups' professional activity (psychologists and mental health workers) and the use of similar coping strategies (see Figure 4).
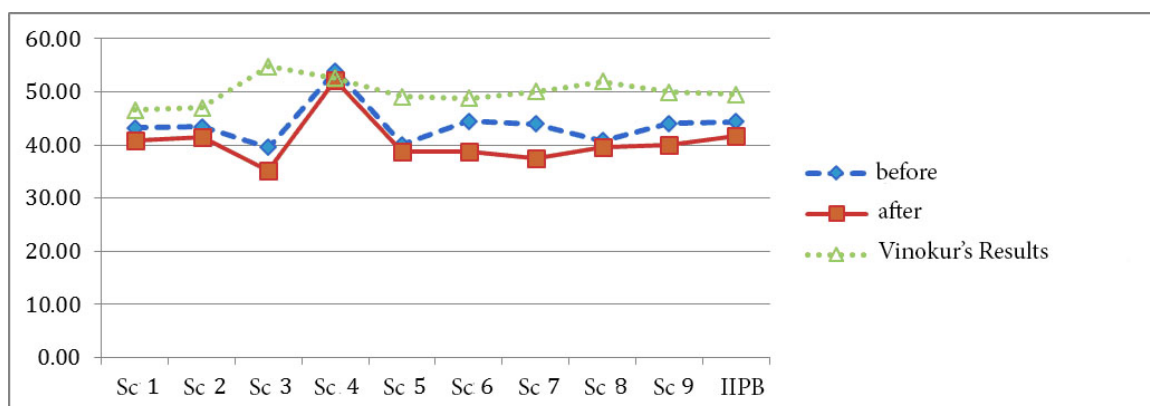
Figure 4. Work Attitude and Professional "Burnout" by V. A. Vinokur

1. Emotional depletion.

2. Work tension.

3. Decreased work satisfaction and feeling of its importance.

4. Professional perfectionism.

5. Self –assessed quality of work.

6. Assistance and psychological support from colleagues.

7. Professional development and self-improvement.

8. General self-esteem.

9. Health and general adaptation.

Integrative Index of Professional "Burnout" (IIPB)

To obtain more objective data, we divided the sample group by ages. Division by work experience resulted in the discovery of similar tendencies, yet they weren't as distinct in view of certain inaccuracies (work experience in the psychiatric hospital or the sector of general medicine was taken into account). For that reason, the age of the participants was picked as a more objective and explicit criterion for group division.

A decrease in professional deformation was noted in nurses aged under 30, especially on the Scale 6 - assistance and psychological support from colleagues (16 points). This points to a positive effect of Balint groups on the nurses' condition. The group shows a 6-point decrease of integrative indicator. At the same time, we must note that the indicators in Scale 5 - self –assessed quality of work – and Scale 8 - general self-esteem – remained unchanged after Balint group sessions.

An equal decrease in professional deformation indicators was noted in nurses aged 31-49. The group shows a 4-point decrease of integrative indicator.

Nurses over 50 showed a decrease in dissatisfaction with work (Scale 3), feeling of a lack of psychological support from colleagues (Scale 6) and absence of career prospects (Scale 7). An increase in professional perfectionism was registered, with the nurses starting to perceive the importance of their work. Yet, on the whole, the group showed an insignificant decrease in the integrative indicator, since senior workers have limited adaptability and Balint groups don't help them much.
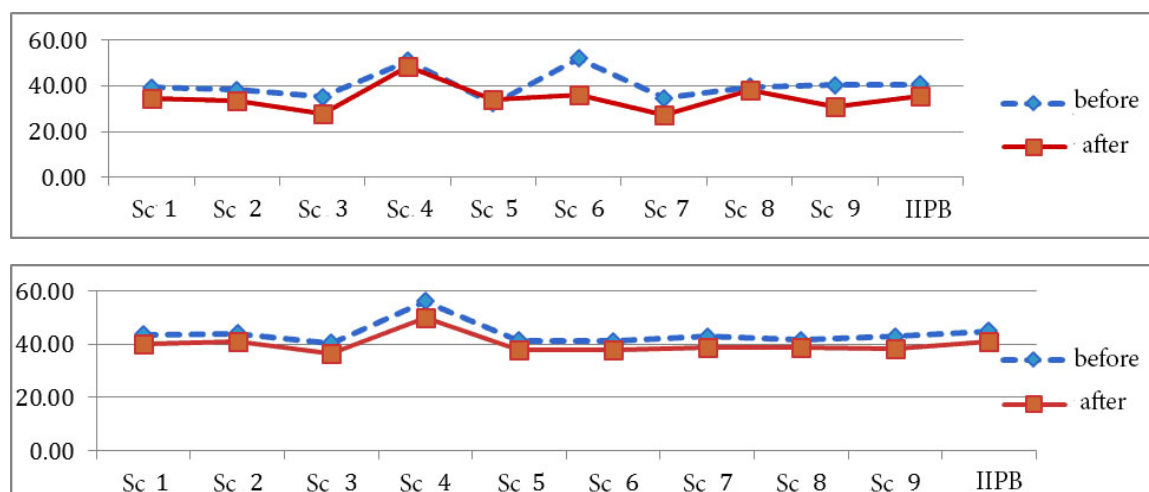
Figure 5. Work Attitude and Professional "Burnout" by V. A. Vinokur (under 30, 31-49, over 50)

It must be noted that initially the idea of conducting Balint groups with mid-level health workers was largely resisted by the psychiatric hospita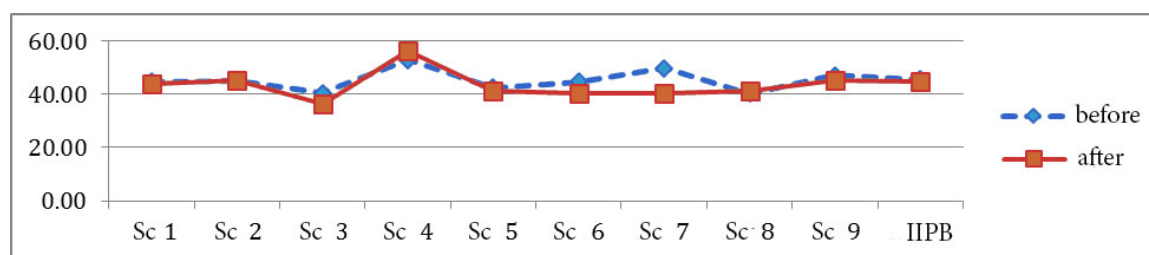l personnel. At the presentation for Balint groups, when hearing that 'Balint group is a safe place, where, in an environment of collegial support you can say "I'm angry with my patient",' nurses would stand up and object –"How dare you, we love our patients!"

Some nurses were trying to sabotage the presentation by walking out. Thus, these people who gave so much warmth and love to their patients were still in the grip of defensive mechanisms of denial and had no access to their own feelings.

During the first few group sessions, nurses were reluctant to share their negative emotions; trust, so necessary in Balint groups, was slow in developing. It became clear that the majority of participants encounter similar cases; increasingly complicated cases were now shared in the group. Lots of suppressed aggression caused by lack of appreciation of nurses, humiliation and degradation was revealed. They were often irrationally concerned that the mental illness may affect them or their family.

At first, there was a lot of criticism for the person presenting the case, it was hard to follow the Balint group rules requiring non-evaluative statements when referring to the case presenter; however, the participants started gradually to acquire an understanding of the spirit and ways of the Balint group.

Despite the hospital management's kind suggestion to attend Balint group sessions during work hours and free of charge, the offer wasn't met enthusiastically by every participant. In view of this, we were even more pleased to hear at the final session, summarizing the results of the first part of the project, that the majority of the participants were grateful to have been included in the project and given a chance to attend Balint group sessions and share their emotions on the theme, "Me and My Patient as a Stress Factor". The majority of nurses assessed the work as a new valuable experience. One of them said that Balint groups "helped people feel they are being taken care of, we began to feel more unified, the subsidiaries and the hospital employees became closer." Another participant noted, "We looked inside ourselves and were given a chance to see our patients in a different light." The nurses stressed the ability to understand themselves and their patients better, among their main acquisition after Balint group sessions.

Thus, based on the feedback and the research results, the following preliminary conclusions can be drawn: mental health nurses are subject to professional burnout; the latter is more pronounced in nurses with a significant work experience. Growing age brings increased professional experience, but also professional deformation, rendering work to overcome it necessary. Based on global experience and our own observations, we recommend Balint groups as a long-term programme for correction of professional burnout in nurses. Our study proved them effective in forming a positive professional culture.

In conclusion, I'd like to note that at the final session the majority of participants voted to continue the project, with a request for group therapy. This led us to outline further prospects of work to overcome professional burnout in mental health nurses. We plan to conduct 15 sessions with nurses who haven't yet participated in Balint groups, as well as senior nurses, psychologists and psychotherapists of No. 3 Psychiatric Hospital and its subsidiaries. Some changes were introduced in the range of methods, allowing the study of both personal characteristics of the healthcare workers as well as their coping strategies and the level of group cohesion. The data obtained will allow us a comparison with the last year's research, resulting in a more detailed and accurate statistical evaluation.

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Balint groups for palliative care therapists -Treating in the shadow of death.

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Abstract

Over the past few years the authors have been leading Balint groups for nurses working in a home hospice and social workers and alternative - medicine therapists treating cancer patients in an oncology institute. The invitation to conduct Balint groups came from the medical system as a way of preventing burnout to the palliative teams. The article will deal with the re-echoing of death in the groups of palliative professionals, as seen by the leaders. In the palliative groups there may have been a parallel process felt by both the members of the group as well as the leaders themselves: what is best palliative care? From the leader's points of view: What is best way to facilitate a group of palliative care professionals? .The article deals with insights that the leaders had, as well as the reflections that were discussed in a training leaders supervision group with regard to the facilitators' role in leading a palliative professional group..

Introduction

Over the past few years the authors have been leading Balint groups for nurses and social workers working in home hospice and a group of alternative medicine therapists treating cancer patients in an oncology institute. The article will deal with the re-echoing of death in the groups of palliative professionals, and its reflection on the leaders.

Research

A study in Israel investigated the knowledge and attitudes of family physicians and the general public towards end-of- life treatments and palliative care (Bentur et al, 2016). It was found that 70% of the physicians reported that they have palliative skills yet only 34 % reported being able to notify bad news to the patient. Only 24% asked their terminal patient's preferences, that is to say that the incidence of doctors that were involved in palliative care in practice was lower than those that reported having the skills to actually treat these patients. Among the obstacles that were identified for referring patients for palliative treatment were the families' understanding that referral meant "death" as opposed to "the

value of life" or the hesitancy of the doctors in prescribing opiates or feeling guilt in not being able to cure. These results made it necessary to provide an adequate supportive system to enable doctors to emotionally express themselves in their palliative care.

Furthermore other studies indicated secondary traumatization (Figley, 1995) and increase in incidence of compassion fatigue among palliative clinicians. However alongside burnout, studies have reported feelings of satisfaction and post- traumatic growth (Tedeschi et al, 1996) among clinicians dealing with palliative care .This refers to improvement in five areas: in feeling of being closer in their relationship to others, seeing new possibilities in life, improvement in their personal strength , a spiritual growth and a more positive appreciation of their lives. As a result of palliative caring they began to develop meaningful relationship and self-awareness in their relationship with peers and family which is called compassion satisfaction (Stamm, 1995; Kearney et al, 2009).

A calling from professionals working in the area

The idea of organizing a Balint group for palliative clinicians came about when two of the leaders ran a Balint group for social workers in the Negev, in the south of Israel. Two members of the group worked on the home hospice and they presented complicated and interesting cases from the homes of their palliative patients. The question raised in the group was how to emotionally accompany the terminal patient towards the ideal of "a good death"?

Family practitioners

Many family doctors wrote about their experiences accompanying terminally ill patients and their families in the book "Stories of Doctors" (Matalon and Avrahami, 2015)**.**

In the poem "Let the silence come", a doctor expressed the inadequacy of words and advice given by the doctor at these moments:

"Let the silence come,
Let me stop.

May my eyes be no more teary and seeing
And my ears stop listening to the noise
 From the buzzing of doctors and therapists

From words of hope and consolation

From the lack of knowing and helplessness

And release my holding, that's gone." (Gili Ofer-Bialer M.D)

Our experiences

In regular Balint groups often palliative cases are presented .In our case in a primary care setting we were asked to organize a Balint group only for palliative care professionals . Members of both groups can be seen as having a passionate , throbbing sense of mission in them, which the Balint leaders themselves also felt (Balint's apostolic function).Therefore in the palliative groups there may have been a parallel process felt by both the members of the group as well as the leaders themselves: What is best palliative care? From the leader's points of view: what is the best way to facilitate a group of palliative care professionals?

In our presentation, we should like to provide you with sensitive insights that the leaders had, as well as the reflections that were discussed in our training leaders' supervision group with regard to the facilitator's role in leading a palliative professional group.

The groups and their leadership:

Balint group for alternative medicine therapists (Matalon and Rabin)

The group comprised 16 alternative therapists from the oncology department of a big general hospital in central Israel. At the beginning there was much enthusiasm in the group and the members shared emotionally laden cases. The leaders paid much attention to emotional sharing of these very intense cases, as is usually done in a regular Balint group. However the cases often emotionally flooded the participants. .The leaders at this point felt that the members may have been in competition with one another as to who would bring to the group the more dramatic emotional case or the one that had the most suffering. The leaders now felt even more emotionally flooded, and sometimes helpless, and asked themselves how to navigate the group so as to promote emotional insights for participants. Sometimes facilitators felt that the pain and depression of cases presented detracted from the sense of togetherness of the group itself. In an attempt to deal with what was happening in the group the leaders allowed two cases to be presented in a session - responding to the needs of the participants, in order to give more members a chance to present their cases, which is not customary in our usual Balint work. Nevertheless they felt that the presenter was alone and isolated in his pain which added emotional burden in the group process. The leaders felt swept into the passionate emotionality of the group. They then noticed that fewer and fewer members began to participate. The leaders wondered what had happened. Was the constant

theme of coping with suffering and death actually "killing the group"? Was it possible to do something in leadership in order to consolidate the group? Was there another way to protect the participants, to enthuse the group and keep it alive? Could it be that the problem was that the leaders concentrated only in processing emotional issues which may have actually frustrated participants, causing them to drop out? Did the relatively young age of 35-45 of the participants also contributed to this?

Balint groups generally do not deal with one pre- defined issue. Yet this group presented us with the question: when we lead a Balint group where the issue of death and dying is presented, how do we facilitate the individual member to gain personal emotional insights?

Balint group for home hospice nurses (Shorer)

The nurses work together in a home hospice where they visit the homes of patients. This allows for physical and emotional support, involved in home care. The team comprises family practitioners, nurses and social workers. The duration of the group was two years, meeting every three weeks for one and a half hours. The leaders were a psychiatrist who does not treat ongoing palliative patients and a social worker who is involved in palliative care.

Home hospice work involves the practitioner visiting the patient and his family in their homes. At the same time the palliative caregiver is exposed to the family drama at the most intimate and critical moments of the families' life crisis. The therapist then is a guest in the family home, sometimes an accepted one while at other times met with opposition by the family in their difficult moments. Here we examined the therapist's conflict between his sense of mission on the one hand and the limits of this mission: emotional stress, ethical rules, the need to share the teamwork

The nurses were called occasionally at night or after work hours, for families they treated which add to their physical and emotional strain. Often it is difficult to temporary transfer the case to the nurse on duty because the nurse already knows the family and is attached to them .Alongside the physical and emotional load they also have a sense of pride in the important role they carry out , accompanying a terminally ill patient along his last voyage.. The group leaders were also aware of the multiple roles the nurses have and the difficulties involved because of the intimate relationship they have, not only with the patient himself but also with the families. So in the group, the discussion was related to how to distribute the load, between them, the doctor and the social worker.

The tangle of emotions that were expressed in these groups highlighted the ambivalence of palliative care. It helps with promoting physical relief but also involves the fear of the terminal patient and his /her family, from death lurking around the corner. These emotions echoes the very fears aroused within the nurses themselves. Sometimes families have been waiting for the patient to die since they cannot bear the suffering of their loved one. This gap between hope and despair, life and death, further intensifies the nurses feelings.

Personal thoughts about leading the group (Shorer)

As a clinician who does not work with palliative care, alongside my co-leader who does, I felt like I had entered a special land , "the end –of –life land ". At the beginning of each meeting I felt imbued with a sense of mission that we often talk about in our Balint work. I thought to myself whether it is related to the apostolic function that Balint wrote about? However, sometimes during the group I felt that my feelings changed as I felt the overwhelming loaded position of being a leader. I had a sense of frustration and anxiety, a feeling that I "must" help the nurses in their apostolic, almost sacred and holy duties. I pondered: Maybe following the guidelines of Balint rules and "Balintian questions" could decrease the immensity of the apostolic mission that the group members took upon themselves.

The leaders asked themselves whether it was appropriate to deepen the involvement of the group with emotional issues or respond to their request to receive "practical tools" to gain tips or learn about the concepts of palliative care. It should be noted that sometimes at the end of the session we devoted time to discuss different concepts of palliative care. I wondered if it was an escape from emotional processing of experiences in the group.

Reflections on the group as processed in the training leaders supervision group

In the training group for leaders, I shared my feelings about co- leading with a social worker working in palliative care. I felt enthusiasm leading the group. I then realized insightfully that maybe this Balint group helped to keep me from the fear of my own death, maybe even helped me to "be vaccinated against my own death". However, I often felt that my lack of experience in palliative care was a disadvantage and I wondered how much I could actually contribute to these devoted caregivers? I shared my feelings of happiness and fulfilment at the end of each group meeting and how relieved I felt that I was able to return to the "Land of the Living". A question that was asked in the training leaders' supervision group was how this duality affected our leadership goals? Did the members of the group perhaps try to defend me

in my role as a "foreign citizen to terminal care "and therefore may not have shared more delicate and more difficult issues? I admitted that sometimes I felt safer when my co-leader brought up for discussion specific palliative care issues. Was this my way of not dealing with leadership issues? Should leadership with palliative therapists be more flexible? Is it not at the expense of emotional sharing? Did the nurses project onto me, the only doctor and the only man, feelings which they may have had about the hospice doctor not being part of the group? Or maybe they tried to protect me in the group, as they do often towards the absent hospice doctor?

Reflecting the experience of the group facilitator at the third age of the life cycle

My leadership of this special group made me aware of a number of issues. In one of the leadership training meetings we spoke about ourselves as being messengers, called by the system to establish Balint groups to medical doctors or other primary care health caregivers. These care givers are generally younger in age and professionally junior than we are, working in difficult workplaces with the risk of professional burnout. So in the leadership training meetings the question was raised as to how far we, as facilitating Balint work, get sucked into the role of "saving", " treating" or "reviving " people working in burnout environments? At one session a question arose as to what extent do we as Balint leaders actually ease or try and alleviate the suffering of professionals working in challenging medical frameworks? At another meeting another issue was raised: the dilemma and emotional impact of separation for a leader who terminated leading a group which he had led for many years. The questions were: "Who will be my successor?" "Who is able to continue the leadership?" "To what extent do we, as dedicated senior Balint leaders, want to make leadership "attractive" to the younger generation?" "How much are we really willing for the younger generation to lead Balint groups?"

Conclusion: Personal Reflections at the time of facilitation

Some of the leaders are well into their professional careers. I personally felt that I was doing an important Balint mission for others, but later I realized the mission was for me too. Over and above the emotional involvement I felt leading the group I felt proud that I was able to gather my resources for an important mission. I felt that there was a connection between the nurses' mission and mine, as a Balint leader. I felt like a soldier conscripted to help the dying to face their final battle. I was grateful to the nurses who allowed me to become part of their calling during which I learned a lot about myself. I studied medicine and psychiatry because

of my own personal traumatic experience related to my father's tragic drowning with me trying to save him without success. The experience of pain and loss and the desire to learn and cope accompany me throughout my life. While leading the Balint group I became aware of my deepest emotions, thinking also about the stage of my personal and professional life cycle and the process of separation. Leading a Balint group, writing this article, discussing with the authors about the meaning of life, as well as sharing my thoughts in the training leaders' supervision group allowed me to contain these feelings. It was like a kind gift for me , "Chesed" (in Hebrew: a present I didn't ask for) something that I was not conscious of at the beginning of my journey- a gift of fulfilment , contentment and serenity in the shadow of death (Rabin et al, 2010).

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Experiencing common issues and cultural differences leading Balint Group sessions in Guadeloupe

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Abstract

A 2-day training session for GPs in Guadeloupe, was an opportunity for French metropolitan Balint Group leaders to observe common issues and different representations, compared to their usual references.

The group worked out well, coming close to each unique situation while highlighting common or different references within.

Common were the professional issues shared by GPs, as family practitioners.

More specific were the cultural and historical references highlighted by the mirror of the group: the ancestors evoked almost as lively characters, the strength of family and neighbourhood links, the image of « mutiny », the fear of « eruption », and the underlying conflict with family members living in metropolitan France.

The doctors seemed to experience specific demands, either to supply missing social services for isolated patients, or take a role within family systems.

Article

The purpose of this article is to share reflections of a Balint leader, curious of experiencing how cultural differences would emerge in the Balint group process, leading Balint Group sessions for general practitioners (GPs) in Guadeloupe, compared to equivalent Balint sessions for GPs in the French metropole.

I had the following questions in mind : how the group dynamic would work between metropolitan leaders and local GPs, would issues at work in the Balint sessions be different from equivalent Balint sessions in the French metropole, and how would cultural differences or specificities emerge in the Balint group process ?

BACKGROUND

The French « Societé Médicale Balint » (SMB) has been proposing cycles of 2-day training sessions including four Balint Groups to GPs for almost 10 years. This is an opportunity for GPs to discover the dynamic and aim of Balint work, in areas without local leaders. They usually appreciate experiencing the Balint group dynamic, even over a short period of time, some of them coming back on a yearly basis, leading to a « recurrent Balint group dynamic ».

That Balint training session in Guadeloupe was planned with teaching GPs from the Caribbean Medicine University when they met in Paris, during the 2016 French National Congress for General Practitioners.

Guadeloupe is one of the French Carribean islands (with Martinique). It is currently known as a French "overseas department "(DOM), while the Guadeloupean people call mainland France, "the metropole".

Writing this article was an opportunity to learn more about the turmoil and violence that the Guadeloupeans have undergone as members of a French colony, administered as a sugar producer since 1635, including extermination by the first colonials, and the importation of black Africans as slaves under Louis the 14th. Guadeloupeans seem to have shortly benefited from democracy, after the French revolution, and opposed the reintroduction of slavery by Napoleon, during the famous local mutiny in "Fort Delgres ".

The two Balint leaders involved were very interested in working with GPs from Guadeloupe, and curious to meet them and discover whether the Balint group dynamic would highlight local cultural differences, without knowing what they would come out with.

METHOD

Two Balint group leaders (myself as a GP leader and a psychoanalyst) flew from Paris for a 2-day training session in Point à Pitre in November 2016. The training programme used mixed methodology, according to French requirements for GP training programmes, including presentations on specific themes and case studies. The chosen theme was « How to improve doctor patient relationship – Difficult relationships », which inspired the choice of situations presented within the Balint groups.

The participants were Guadeloupean GPs, used to work in a local training group. The group members' cultural background was mixed, including GPs born in Guadeloupe, either from local families (descendants of the former slave workers) or from « white Beke » (descendants of the first colonisers), or they came from the French metropole or other French overseas territories.

LOCAL SOCIO-CULTURAL BACKGROUND

Coming to Guadeloupe for that training was a unique occasion to discover a surprising culture, with sincere exchanges with local GPs.

Guadeloupe is made of two different parts. One called « big land » (grande terre), a flat area gathering most of the economic life, construction and beaches, and the other « low land » (basse terre), a volcanic area, with a luxurious tropical vegetation, with banana plantations where former colonial beke families used to live.

The volcano « of the Soufrière », was seen in the background, half of the time covered with clouds, as a reminder of its last eruption of gas in 1976. It seemed to haunt « low land » city, seeming half abandoned since.

We arrived on All Saints Day, and discovered the Guadeloupe tradition to gather in lively graveyards made of black and white graves, illuminated by white and red candles for two days. A very stunning event, that gave us a spirit of how Guadeloupeans gather to celebrate their ancestors , as present members of the families, without sadness or heavy mourning.

A reminder of the Guadeloupe history of slavery, is « Fort Delgrès », named after the mulatto leader of a mutiny held to resist Napoleon's restoration of slavery, after its abolition during the French revolution. History reminds they had blown up the Fort to avoid surrender. That mutiny seemed a strong symbol in Guadeloupeans' mind, as a reminder of their half sleeping rebel identity, towards the French metropole.

Nowadays, the Guadeloupe population living in French metropole or abroad seem as important as the population living in Guadeloupe.

RESULTS

The experience of the Balint Group sessions

In a comparable process to equivalent 2-day Balint trainings, the two Balint groups of the first day dealt mostly with professional issues linked with GPs' responsibilities and difficulty understanding their patients' own representations and values.

One case dealt with a diabetic patient, who did not seem involved enough in the care process, and came back too late to control the evolution of a skin infection. This raised issues linked to guilt, misunderstanding and incapacity for the doctor.

Another dealt with a non compliant patient, changing doctor when she started having stomach ache, and was brought back by her daughter years later, at the terminal stage of a stomach cancer. The group work included receiving part of the burden of the guilt feeling of the doctor, and extended to an examination of the patient's representations when choosing to change doctors, probably linked to local alternative medicine.

On the second day, two GPs from local origins had the group work on cases including strong involvement of the doctor within the familial environment and local representations of the patients. The confidence of the group helped work more on the doctors' own representations and values, linked to their cultural background.

In a third story, a doctor felt overwhelmed by the demand of a patient of the neighbourhood to cope with the absence of familial support after the death of his wife. The group helped the doctor feel the link to her own ancestors, with a potential feeling of a debt, when realising the patient's deceased wife was the best friend of her grandmother. She was also stunned by the weakness of the public social structures to cope with the isolation of that man and the opacity of the parallel supports of his daily life. As a result she had felt for a while the pressure as a family physician to compensate in a concrete way for the missing familial support.

In a fourth case, a local doctor very involved with a family felt the burden of guilt, having contributed to the delay in diagnosis of the lung cancer of an old man, yet working in agreement with the patient and at his own pace in medical support. She carried the burden of a great guilt, reinforced by the intervention of a daughter coming back from the metropole. That daughter had then pushed the mother to be operated for a thyroid tumour, according to metropolitan doctor's advice, which caused her death, while it was found to be benign on the biopsy. The doctor seemed to be tightened in the family conflicts, and willing to accept different burdens, from guilt to coverage of embarrassing elements to prevent the family system from blowing up (if they knew the thyroid tumour responsible for the mother's death was finally benign). The group dynamic was to support the colleague's empathy to the family, while proposing her to step back a little from the family dynamic and conflicts. The story highlighted a strong presence of the ancestors who seemed to have accepted a certain fatality and chosen to follow their daughter's will.

Common issues and cultural differences

1- *The group dynamic was progressively built over the four sessions, as for comparable Balint training in metropole.* It enabled the group to widen progressively its scope from professional issues to social links. They worked on the first day on fundamental issues linked to medical care and responsibility. On the second day, a good enough confidence among the group seemed to enable to widen the scope and work on the familial interrelations, as well as local cultural representations.

2- *The Balint group helped the participants work on the doctor patient relationship and perceive differences in representations, as in other Balint groups.* The doctors could alternatively perceive the patients' representation and their own. The group helped them step back from such feelings as anger, disappointment, feeling of failure to restore their self confidence and empathy to the patients.

3- *The Balint Group identified specific issues common to GPs as family physicians.* Different situations highlighted the risk for family physicians, as exposed to both medical care and defaults in family systems, to compensate as active members of the family systems. While group work can help the family physician find the proper distance either to support the missing function within the family on a symbolic basis, or as a neutral witness. Such as a little step, « like on the side of a volcano », to be able to observe the dynamics and conflicts within the family, without « fearing an explosion » or « trying to cover the truth ».

4- *On the other hand, meeting Guadeloupean doctors helped the metropolitan leaders discover local cultural representations.* The Guadeloupean doctors' link to family dynamics seemed particularly strong as family physicians, making it more difficult for them to limit their answers to family demands. Further, the metropolitan leaders were surprised by the links to deceased ancestors, and the influence of images illustrating the tropical and volcanic nature of the island, the reference to history and the links and conflicts with the French metropole.

Specific influence of local history and cultural environment

1- *The difficulty of some doctors to understand the lack of compliance of some patients, seemed related to the hidden influence of traditional medicine.* Misunderstanding and lack of compliance was more quoted by doctors from other origins than the local black community. Colleagues in the group remarked that these patients might have different representations of health, and might be influenced by traditional medicine.

2- *Most doctors seemed to have sometimes the perception of a hidden truth, or hidden symptoms, related to a parallel hidden medicine or economy.* For instance, the coexistence of official medical care (doctor, nurse, social assistant), and unofficial networks to support the individuals (family, neighbours, housekeeper, church group visiting lonely persons, sometimes secret children). They also had patients hiding such symptoms as hypertension, challenging the doctor to find it.

3- *The strength of family bounds seemed particularly strong in Guadeloupe, making the burden of family demands hard to limit for family physicians.* The more so as local doctors were also tied by their loyalty to their own family and ancestors.

4- *The strength of family links seemed equivalent to the weakness of public social structures available for patients isolated from their families.* All doctors quoted situations where it was particularly difficult, and almost impossible, for them to say no to some patients' demands after opening hours. This seemed significantly different from the metropolitan habit to focus on coordinated night guards.

5- *A unique cultural link to deceased ancestors, which somehow seemed to have a place in the mirror effect of the Balint group.* In the group dealing with deceased patients and the remaining conflicts between their children, these ancestors seemed almost present in the group in the way they were quoted. Their free will seemed present in the group's elaboration perhaps a parallel with the deceased members of families visited on All Saint Day in the illuminated graveyards.

6- *The evocation of conflicts with family members living in metropole seemed to echo the history of conflicts between Guadeloupe and metropole.* The story of the family

conflict between a sister living in metropole and brothers and sisters living in Guadeloupe, concerning the parents' health and death, was an occasion for most doctors to echo their own difficulty in facing the demands of family members living in metropole. They felt that they had to obey the alleged superiority of metropolitan doctors, mirroring the former relationships between metropole and Guadeloupe.

7- *The dynamic of containment, desire of mutiny, or fear of explosion, seemed to echo both historical references and cultural images of a tropical and volcanic island.* The evocation of conflicts within families seemed underlined by the fear of seeing conflict explode, leading to dynamics of containments, or fear of explosion in the presenting doctor's speech. The image of mutiny was also quoted, concerning the reaction of waiting patients in the waiting room.

8- *Evoking the image of the fear of a volcanic explosion within the group seems to have helped symbolize the intensity of the underlying hidden conflict.* It seems to have helped free speech and reassurance within the group afterwards. As if the strength of cultural images had fostered the ability of the group to symbolise.

DISCUSSION

The Balint group process seems to reinforce the experience to get to know each other's unique cultural identity while a member of a group, with back and forth between identification links and openness to each other's differences.

It is an opportunity to « meet with each other's unique representations », while discovering the uniqueness of each individual story, with the specificity of each presenter's cultural background, and his patient's.

In that perspective, leading a Balint group in a context of cultural differences, seems a chance to strengthen that specific feeling of complementarity between common and different values while meeting each other's representations and identity, as unique persons within a Balint group. This reinforces one of the core values of Balint groups, contributing to get to know each other, while acknowledging both identification and differences. A Balint group contributes to express identity and cultural differences once confidence has been gained.

An interesting idea was to identify the strength of local Guadeloupe culture and its images mirroring some cases, as a potential tool to symbolize the dynamic of underlying conflicts, and foster the development of the group.

CONCLUSION

The experience of leading Balint Groups in Guadeloupe, including the meeting between metropolitan leaders and local participants, helped highlight fundamental principles of Balint groups.

As a professional process it highlighted transcultural issues, linked to the GPs' professional responsibilities and unique doctor patient relationship.

The presence of common issues and differences of approach seemed similar to other Balint groups, as part of the Balint group dynamic. The group coming close to each individual situation, bearing

differences in its uniqueness, while working on the mirror effect of the group to highlight common issues.

As a cultural process, the mirror effect of the group seems to have revealed shades related to the unique Guadeloupe sociocultural background : the strong presence of ancestors, the impregnation of family roots and links within Guadeloupean daily life, in parallel with poor public social structures, and representations of conflicts referring to their specific history. Particularly, when dealing with conflict and power between local and metropolitan members of families, evoking the symbols of « contention », « eruption » or « mutiny », as a mirror of both social and geographic history.

For the leaders, having in mind a specific interest in exploring common values and differences, may uniqueness, and contributing in building a « neo group spirit », with a demand to pursue equivalent training next year.

HOSTING DIVERSITY: CHALLENGES IN LEADING MULTIDISCIPLINARY BALINT GROUPS

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Abstract

Our paper offers some reflections about the Congress questions regarding multidisciplinary groups

challenged by patients' sociocultural issues through the example of a three and a half years Balint group within a cancer aftercare unit. Firstly, we introduce the conditions of a Balint group within a care institution. Secondly, by describing the group work, we try to analyse the parallel process between the heath care team difficulties with "foreigner patients" and the group's psychodynamics. We share the difficulties and the questions raised by this experience – to be discussed with reference to the underlying Balint theory in order to reflect on the leader's function. Hosting diversity isn't the core function of care? Hosting otherness seems to us to be the main task of a Balint leader.

HOSTING DIVERSITY:CHALLENGES IN LEADING MULTIDISCIPLINARY BALINT GROUPS

Introduction

This paper proposes to share the experience of a three and a half years Balint group within a cancer aftercare unit. Hosting diversity was the core of this experience in three senses:

 firstly, regarding the team, composed of a general practitioner (GP), two haematologists, a psychologist, a social worker, a physiotherapist, a psychomotor therapist, a nutritionist, nurses and aide-nurses ;

- secondly, regarding patients who came to Paris from French Overseas Territories and from other countries to have treatment for their cancer ;

- and lastly (but not least importantly), regarding the leader, who is not French.

   Our wish is to try to offer some reflections about the Congress's questions through the example of a multidisciplinary group challenged by the sociocultural identities of participants and patients.

Balint groups in a cancer aftercare unit

Analysing the demand

  The first step in organizing the Balint group within this institution was to clarify the initial demand. Even though the institutional problems weren't the object of our intervention, it was important to understand the context which could permeate the group's dynamics and the unconscious choice of the cases presented during the sessions.

In a previous interview, the nurse manager and the head doctor described the difficulties of the health care team (HCT) in taking care of patients coming from French Overseas Territories and from other countries, because most of them come alone, have no family in Paris and stay several months in the

institution. This situation leads health care professionals (HCPs) to throw themselves into their relationship with these patients, who regard the institution as if it was their home and the HCT members as if they were their families.

This kind of relationship raises many difficulties for each HCP, but also disturbs the HCT cohesion. Recognizing these difficulties, the nurse manager and the head doctor were concerned about the risks of HCP burn-out and considered that the HCT needed help from an external professional who had experience in the field of cancer care.

We cannot ignore, in this institutional demand, the parallel between the suffering of the patient and the suffering of the HCT: both torn between impotence and omnipotence, between hope and despair…

The 'cumbersome metaphors of cancer' (Sontag, 1979) which likens its treatment to a war in which patients - and HCT – must take the place of 'ordinary heroes', remain present and are nourished by the advances of medical science.

Confronted with disease and death, HCPs can be brought to think that they are the only ones (or among the small minority) to have the privilege, the skill and the courage to face this work; to be able to deal with all the emotional charge of these demanding situations. This 'phallic heroic identification' may lead them to avoid any reflection and to act out this imaginary position in their relationship with patients (Gaillard, 2011) .

The Balint group, centred on clinical cases, can offer HCPs the possibility of discarding   social speech and of questioning their own defences and being able to take better care of patients.

Clarifying the setting

The agreed setting was a one and a half hour Balint group every two weeks, so that the HCT shifts could offer each HCP a monthly session. The nurse manager and the head doctor did not participate. The group took place in the workplace and within working hours but the HCPs' participation was not obligatory. Once they had chosen to attend the group, HCPs were asked to be present at each session.

In institutional groups, it is not easy for participants to take the risk of using their own words, to expose their doubts and feelings in the presence of colleagues with whom they work every day. Any questioning could be feared as a judgment, a narcissistic attack, and a threat to their basic security and resistances and mechanisms of defence seemed inevitable. The clarification of the setting, a clear definition of the task before the group, the quality of the framework and its reliability, but also the

'internal frame' of the leader, can make this initially presumed 'dangerous' Balint group become a space for exchanges, thought and creativity.

Describing the group's work: the parallel process

1. Two territories: The HCTs and the patients'.

During a first stage (corresponding approximately to the four initial sessions) HCPs complained about institutional functioning, work conditions – and even about patients! Each session began with these complaints, which had different functions in the group's dynamics: offering (to the leader) the image of an undivided group; testing the leader's position; showing the HCT's conceptions of a 'good' institution and an 'ideal' patient.

We were aware of the fact that complaints could maintain the suffering, requiring each participant to hold the place which is assigned to him/her in the undivided group, thus avoiding any confrontation of subjective positions. So, at each session, we gathered the complaints, but we invited the group to choose a clinical case to discuss together.

In this period, the groups frequently chose the cases of 'foreign patients'. They stressed the difficulties of caring for them, presenting several 'rational' reasons, mainly their misreading of these patients' cultural background – as if it would be necessary to have a 'university knowledge' of each country's customs, traditions, etc, in order to take care of these patients !

These defensive ideas had the function of establishing different 'territories': HCPs and patients. In the words of Deleuze (1990), 'the territory it is what differentiates me from the Other, what separates me from him. It underlines distances – and differences: 'you are like that, I am otherwise'[14].

The group's work on different cases of patients coming from the same French Overseas Territories (Polynesia) brought the HCT to observe that every individual interprets the different aspects of the ancestral traditional culture in their own way. Realizing this allowed HCPs to understand the person behind the cultural aspects and helped the HCT to recognize and demonstrate, within the Balint group sessions, the differences among the group's members.

2. Moving into the HCT's territory

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[14] . Cultural aspects were the differences which HCPs could then explicitly name; hidden behind these differences, the dissimilarity was the fact of having – or not – a cancer.

Then, the location of the territories moved: from the outside to the inside of the HCT. The discussion of clinical cases was the occasion for the HCPs to talk about their perceptions of the patient's behaviour.

One HCP talked about Vahina. This young Polynesian woman had come alone from the Marquise Islands. Before becoming ill, she had never left her island. She was described as 'a padded, silent and not very kind young woman'. She did not communicate with HCPs. They did not understand her attitude.

> So, Vahina's silence was differently decoded according to the differing professional knowledge of the HCPs: the doctors considered the possibility of adverse medication-effects ; the psychologist saw it as a sign of depression ; the social worker, a consequence of social isolation ; the nurses, the manifestation of asthenia ; the aide-nurses, an effect of her timidity…

These different points of view were initially presented as 'exclusive ', as a way for each professional to affirm their knowledge and the importance of their own approach. As rivalry and power stakes could emerge as an obstacle to the group work, we invited each HCP to clarify their point of view, bound to their function, to explain the scientific, theoretical and ethical references that underlie their practices.

This 'translation' work led HCPs to discover that their specialist knowledge is, like our mother tongue, 'only a grip, among others, on the reality' (Huston, 2008) . This understanding operated a shift that helped to dissolve the barriers between the different theoretical ideas of the HCPs (and of their power) that were impeding the teamwork.

Thanks to the emergence and the confrontation of different approaches within the group, the diversity and the individuation became possible.

A nurse said that Vahina seemed to communicate with the cleaning lady and suggested that the group could invite this lady to participate to our sessions. So Nadine came to the group. She told us a little about Vahina's personal history and about the patient's difficulties in being alone and far away from her family. Nadine revealed to the group how Vahina was grateful to the HCT for hosting her in this unit. From that moment, the HCT's perception of Vahina's behaviour changed – as did their attitude toward her. Nadine and her colleagues were invited to the group sessions and considered as members of the HCT.

The recognition of different – but complementary – professional perceptions appears to us an important aspect of multidisciplinary Balint groups: it enables a better grasp of the function of each professional and hence a more effective collaboration.

Hosting diversity within the HCT is a necessary step towards seeing patients as individuals: to recognize them in their diversity and their singularity.

The next step in this group's work was to admit differences among people of the same profession: even if they had the same professional background., nurses had different perceptions of this or that patient, because they are not only peers, but individuals – each with his/her own values, sufferings, limits… like every human being.

3. Going out of the territories

As the group members learned to talk in their own names, recognizing their affiliations (to a profession, to this institution, to this team) without denying their differences – and even by affirming their personal perceptions, the group's work changed.

Firstly, HCPs could then take on the way in which they were – each one in his/her own way, emotionally touched by these 'foreigner patients' who asked them to 'replace their families' during their stay in Paris. HCPs felt that these patients expected from them a friendly relationship, a greater commitment.

As if speaking in their own names could be dangerous, HCPs reverted to talking about 'foreigner patients' as an 'entity'. But rapidly, the question of affective aspects of HCP-patient relationships emerged regarding the case of a French patient. And from there on, the group could broach the interpersonal aspects of each care relationship, identifying some transference and counter-transference movements.

The analysis of the counter-transference – defined by Winnicott (1992) as what 'interferes with the professional attitude' - is a main function of Balint groups. For these institutional groups, understanding the feelings of being overrun by what they perceived from patients' demands, analysing their commitment in their relationships with each patient ('foreigner' or not), identifying their projections on patients' situations, setting apart their perceptions of patients' suffering from the patients' experiences enabled HCPs to care for them better.

Vahina had been living for several months in the unit. HCPs learned how to communicate with her, respecting her silence, but being present and supporting her throughout this period. But her treatment failed. The haematologists discussed the options of further treatment and decided on palliative care, so that Vahina could go back to Polynesia to join her family. The HCT assisted Vahina in this difficult

situation. They were disappointed and sad – as she was. But they felt they had done their best to care for her.

<u>The leader's role</u>

In this process, the leader was at the very beginning chosen – by the nurse manager and the head doctor - as a 'foreigner', in the sense of being a professional who did not work in the institution but also a 'native', in the sense of having a professional experience in the cancer care field.

Derrida's reflections on hospitality helped us to understand this situation (Derrida, 1997). The etymology of the Latin word 'hospitality' evokes a double sense: 'hostis' means the host but also the enemy. Rey (1998) stresses the relatedness between 'hostis' (the foreigner, the enemy) and 'hospes' (the host), both coming from the verb 'hostire' , meaning 'to treat as an equal, to compensate, to pay in return'. Ideally, hospitality is unconditional: 'the host is supposed to welcome the other without asking for their name, their origins or their faith' (Rey, 1998)…

   Yet, in the institutional space, hospitality takes place within a pre-established order, in which the rules and the asymmetry of roles may lead the HCT to practice what Derrida calls 'hospitality': hospitality under multiple and contradictory conditions (Rey, 1998). In this context, HCPs may oscillate between integration and assimilation, between the desire of otherness and the desire of similarity.

A parallel process occurred in this group work – with respect to the exchanges among participants and the relationship between the group and the leader – the 'host'.

We can note that in the French language, the same word is used to designate the person who greets and the welcomed person. In these groups within the institution, we were a 'host' in this double sense of the French word.

We were 'invited' by the group to respond to HCPs' complaints, to take sides, to make suggestions about how to take care of their patients.

We have tried to keep in mind Balint's advice : the leader should not supply answers or give advice as this would increase the oral greediness and the needs of the participants; nor should the leader appear as almighty, omniscient, which would only enlarge the group's 'ocnophile' dependence towards him/her (Balint, 1966) .

We have tried to be a 'host', creating' a secure but challenging atmosphere' and encouraging each one's commitment to the group work. These essential conditions for a Balint group are even more important in this institutional setting, for HCPs may feel 'in danger' of disclosing their subjectivity when talking about clinical cases.

We were convinced that Balint groups in institutional settings may offer HCPs a space to reflect on their way of being a HCP – provided that the leader comes to refocus the work of the group on the clinical practice, by giving the work to a person (the professional) challenged by that of another person (the patient).

This challenging group experience corroborates this opinion, because, over time, as the group constituted for HCPs a 'holding' function', each professional was able to express himself. Over time, the group work helped the HCT to repair its 'alpha function' (Bion, 1962), i.e. its potential to contain patients' fears, enabling them to support the psychic process which transforms distress into sense.

Over time, we have tried to keep an open-minded attitude to host otherness, listening carefully, being aware of unconscious issues and observing the psychodynamic group process. We did not use 'pushback', round table or other techniques, but encouraged free association and non-judgmental exchanges.

<u>Conclusion</u>

'How to welcome the other one without losing ourselves?' (Derrida, 1997): it is the main question of 'hospitality'.

And maybe, rather than technical questions, the self-questioning that we should keep in mind as leaders could be about our capacity to host alterity (our own and the other's) in our inner space in order to hold up this 'extraordinary position' by remaining, oneself, an 'ordinary person' (Winnicott, 2008).

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EXPLORING DIVERSITY IN REMOTE AREAS OF AUSTRALIA'S NORTHERN TERRITORY – BALINT IN THE NEVER NEVER VIA TELEPHONE

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Names & places have been changed, and the story is an amalgamation of true episodes, in order to preserve confidentiality

Abstract:

This paper describes a unique Balint group initiative, involving Aboriginal cultural educators working in partnership with medical educators to facilitate Balint groups. Participants were junior doctors undertaking twelve-week general practice placements in several remote Aboriginal communities in Australia's Northern Territory. Many of the participants faced significant challenges in providing medical services to Aboriginal people in small, isolated towns and communities.

The Balint group method was adapted to be delivered by teleconference to the junior doctors. Flexibility was important in ensuring cultural safety for the junior doctors and the cultural educators.

This paper describes the pivotal roles played by the Aboriginal cultural educators in the planning and delivery of the Balint group project. It also raises important issues associated with the introduction of the Balint group process to Aboriginal and non-Aboriginal health practitioners working with Aboriginal people.

Presentation:

In this presentation we will be talking about doctors who are training for general practice undertaking Balint group experiences in remote locations in the Northern Territory of Australia. Names, places and patient details have been changed to ensure patient and community confidentiality.

I am sitting in my home office in Hobart, Tasmania. Through the window I watch snowflakes gently settling on the grass and leaves in my garden - quiet peacefulness. I pull the speakerphone to me across the desk. I am about to take an imaginative and emotional journey to very remote areas in tropical northern Australia. I am working for Northern Territory General Practice Education (NTGPE), the organisation responsible for training doctors for general practice (family medicine) in the Northern Territory, Australia.

I dial the number and enter the connecting code. There are clicks and bleeps as voices come on line – Pre-vocational General Practice Placements Program (PGPPP) doctors. The ten participants are young PGPPP doctors in their second year of graduation. Some were trained in countries other than Australia. They have mostly come from tertiary teaching hospitals in Australia's capital cities, where sterile, white, technologically advanced operating rooms and consultant grand rounds abound. These junior doctors are used to the latest medical advances being offered to patients, in an environment where everything is well organised and under control. The majority have never been to the Northern Territory before, let alone been placed in a remote Aboriginal community for twelve weeks. Many have never seen an Aboriginal patient before. Culture shock is very real to these junior doctors.

It is early, before their first patients arrive. Their voices are concise, healthy and fresh. They are phoning in from plain, functional clinic rooms in remote Aboriginal communities scattered across the Northern Territory. This is their first Balint group session with me and I am leading their group.

'Hello, I am John from Wurli,' says one.

'I'm Donna from Galiwinku`, says another.

'And I'm in Maningrida,' says Paul.

Another doctor says she's from Jabiru, a mining village on the edge of Aboriginal land. Doctors from other scattered communities throughout the Northern Territory join the teleconference, and announce themselves.

Then Richie from Darwin comes online. He says, 'Hello, I'm Richie Fejo, NTGPE's Senior Cultural Educator. I have with me Nangala and Lizzie. We are the NTGPE Aboriginal cultural educators and we met you all at your cultural orientation sessions.' Richie, Nangala and Lizzie go on

to say from where they come, their connection to their land and kinship system (their family and cultural connections.)

We go through a round of introductions. The doctors tell the group who they are, their adjustments to remote Aboriginal communities and the things they like about those places. Sometimes this is the beauty of the landscape, sometimes the warmth of their acceptance by Aboriginal Health Practitioners and sometimes simply the fishing. Their expression of culture shock, anguish and overwhelmed feelings come later.

'Who has a case?' I ask.

Cynthia presents: 'I'd like to tell you about DL, a 20 year old Aboriginal man brought to the clinic with fluctuating consciousness and shortness of breath. He had two heart valves replaced when he was 14 years old when he travelled from this tiny, remote Aboriginal community to Adelaide for his major heart surgery. His heart valves were destroyed by rheumatic fever – common here and in third world countries, but almost unheard of in other parts of Australia. He doesn't take his prescribed medications and doesn't restrict his fluid intake, which is so hard in the tropics. He smokes marihuana and sniffs petrol. I have the impression that he is frightened that somebody or something is going to catch him and hurt him. He disappeared from the community and went out bush when the cardiologist was visiting and absolutely refuses to travel to the hospital in Darwin – 400 kilometers away with travel only by aircraft. The nurse tells me he is an outcast from the community and his grandmother is the only person caring for him. I feel overwhelmed and my efforts are futile.'

The group's speculation begins. Group members express empathy for the doctor. The Balint group members struggle to put themselves in the shoes of the patient and his family.

I ask, 'What might it have been like for an Aboriginal teenager, who has spent his whole life in a remote Aboriginal location, with all his cultural beliefs and traditions, to be plucked from his family, his country, his dreamtime, to be flown a thousand physical kilometers and one million cultural kilometers away to a major, tertiary teaching hospital to have his heart opened and its valves replaced?'

Gradually, with questions and prompts from the cultural educators, the group moves around its imagination of this young man's Aboriginal world.

Now for the background to this unusual Balint group meeting. The PGPPP Aboriginal health telephone Balint groups commenced in July 2012 and continued until January 2015, when the Australian Federal Government suspended the national PGPPP training program.

The project had a two-year gestation, starting with face-to-face Balint groups with Aboriginal cultural educators in the Northern Territory in Darwin in 2010. The first groups involved General Practice supervisors and medical educators. This gave the Aboriginal cultural educators an experience of the Balint group process. They immediately warmed to the Balint group experience, with its story telling and conjecture on the doctor-patient relationship. Most importantly, it felt safe for them.

Then followed a lengthy period of consultation and exploration of the possibilities of introducing Balint groups to GP registrars and/or PGPPP doctors enrolled with NTGPE. There was a two-day intensive face-to-face meeting with the Aboriginal cultural educators. This meeting laid the foundation for Aboriginal cultural educators to participate in Balint groups with doctors training for general practice. During this two-day consultation time the Aboriginal cultural educators spoke of their cultural connections to their people and their lands – their Aboriginal beginnings. Likewise the medical educators spoke about themselves - how and where they were born, their families and how they made their journeys to the present.

Many concerns were expressed during the initial planning meetings. The following were some of the issues:

- *The isolation of Balint group members and the associated communication difficulties*. Would the voice on the telephone be sufficient to engender trust? How should the Balint group leaders and Aboriginal cultural educators react to distress when they are so far away from the participants?
- *The cultural complexities facing these junior doctors, who are working in remote culturally rich Aboriginal communities*. In what ways will the Aboriginal cultural educators speculate in the group to bring to light cultural beliefs and practices to explain seemingly mysterious events in these remote locations?
- *The wellbeing of the Aboriginal cultural educators, who are not medically trained*. How will the cultural educators manage the vicarious trauma of listening to heart-rending stories about their people that resonate closely with their own lives and losses – even more so if the person being discussed is from their own community, and the patient is known to them. How will the Aboriginal cultural educators feel about being in a Balint group with articulate, authoritative and sometimes culturally naïve junior doctors from major teaching hospitals? How can junior doctors be encouraged to tell their stories without the use of medical words, especially if they were trained overseas? When they do use medical jargon, how is it handled, and by who? What happens if a junior doctor talks about men's business or women's business, and an Aboriginal cultural educator is of the opposite gender? How are taboo subjects dealt with? How will the Balint group leaders, participants and Aboriginal cultural educators deal with possible racist comments?
- *Confidentiality and safety of patients and clinical staff*. How will confidentiality be maintained when there are conversations about patients in remote small communities?
- *Trust and safety within the Balint groups*. A new PGPPP junior doctor group will form every 12 weeks. Can one run effective and safe groups on the phone without prior face-to-face meetings? How will distress of any group members be detected? How will the Balint group leaders and Aboriginal cultural educators respond to group members' distress? Will PGPPP doctors feel they are being judged by their performance in the Balint groups? Will they fear that this might jeopardise their term assessment? Will the medical educators and/or Aboriginal cultural educators be perceived as being in a powerful position in relation to the PGPPP junior doctors and thereby create anxieties about full participation and revealing their vulnerabilities? How might the Balint group method be adapted to the general practice training situation?

From this and subsequent meetings it was recognised that it would be essential to be flexible in adapting the Balint group method to these new and unique Balint group circumstances.

The following adaptations from the 'traditional' Balint method were made as the need arose, that is if one can say there is a 'traditional' Balint method.

- Case presentations were pre-arranged. Each participant was required to present a case and they knew who it would be in the week before the Balint group meeting. They were told that no special preparation was required. It was evident that most had thought about the case before the meeting and sometimes that helped them formulate one or two questions for the group.
- 'Push back' was not used, so the presenter stayed in the group and participated in the discussion.
- The name was changed from Balint groups to Reflective Case Presentations. This came about because a prospective participant looked online and had the idea that Balint groups would involve dangerous delving into the participants' psyche.
- Leadership interventions were adapted to suit the unique circumstances of these groups. The Balint group leader made interventions that were speculative in nature - role-modeling speculation for participants. During the teleconferences the leader

occasionally turned his or her attention to individual participants, especially when their voice had not been heard for some time. The Balint group leaders sometimes invited the cultural educators to speak and sometimes questions were directed to the Aboriginal cultural educators.

- Aboriginal cultural educators made unique contributions to the Balint group discussions. They often held back and started speaking in the second half of case discussions. They sometimes told stories of their own lives that were reflected in the case. This added enormous poignancy to the case discussions. Group members asked the Aboriginal cultural educators about their feelings when talking about their lives. Occasionally the Aboriginal cultural educators told horrific stories, which added even more to the emotional intensity of the case presentations. Particularly heart-rending were stories involving payback and perceived punishment for Aboriginal cultural transgressions. It was these discussions that raised anxieties about vicarious trauma experienced by the Aboriginal educators. They developed a method for de-briefing after each Balint group session that involved only Aboriginal cultural educators.
- Of particular interest were the Aboriginal cultural educators' speculations about doctor-patient relationships involving non-Aboriginal cases. Their speculations reflected strong Aboriginal cultural perspectives in relation to the roles and meaning of family and kinship, despite the patient not being Aboriginal. One could say that in this way these case discussions about non-Aboriginal patients were often as valuable as ones involving remote Aboriginal patients.

The Senior Cultural Educator (third author) said this of his experience of this initiative:

'As Indigenous people, we live through and experience the hardships and disadvantage experienced by our families and our extended families. We have lived, worked in or travelled to many of the communities where the junior doctors are based, so our natural empathy and dedication comes from our families, extended family and people.

Participating in RCP's is sometimes painful for us because we are continuously hearing about the sickness in our people. But our experiences form our knowledge, and we use this knowledge to see through the eyes of Indigenous patients when the doctors present cases. We want doctors to remember that there is much more to consider than communication as an issue with Aboriginal people. Doctors need to remember how the illness of an elderly person impacts beyond the doctor/patient relationship to the family, the extended family and to the community.

We know that the training that we give the doctors feeds back to the people in the learning they acquire. This is not only good for our self-esteem and confidence in our own development, but also relevant to the development of the doctors. At the end of the day, knowing what we are doing and knowing what it does is our reward.'

Now back to the Balint group telephone discussion involving the 20 year old Aboriginal man.

The group speculated about the doctor-patient relationship and the different worlds they inhabit. They talked about what the doctor might have represented to the patient, especially in view of the patient undergoing major heart surgery at a young age. There was also a discussion of the patient's and his family's possible fear that he might die away from his community if he went to hospital. So

often Aboriginal families wave goodbye to their loved ones when they are being taken by medical planes on remote air strips to the Royal Darwin Hospital, never to be seen alive again. From a cultural point of view it is tragic for an Aboriginal person to die away from country.

The Aboriginal cultural educators also picked up on the story of alienation of this patient and his family from his community. They speculated about possible punishment of the patient or his family for perceived Aboriginal cultural transgressions. The Aboriginal cultural educators then shared stories from their own communities, which bore resemblance to the case.

After the case discussion was brought to an end and the doctors hung up their phones in the remote Aboriginal communities. I debriefed with the Aboriginal cultural educators. They then met in a quiet place to work through the trauma of the case discussion for them. I also debriefed with the medical educator who facilitated another group of PGPPP doctors, when I needed to.

We regard this initiative of Balint group meetings involving Aboriginal cultural educators and junior doctors posted in remote Aboriginal communities of Australia's Northern Territory, meeting by telephone, as a remarkable achievement. Participants have reported lasting benefit from these Balint group meetings.

Medical Acculturation of Doctors, their Patients and the Balint Group.

Diana Bass

Abstract (please contact the author for full text; diana.bass@kcl.ac.uk)

For the past twelve years I have been a co-leader of a Balint group for doctors who are in a

post graduate training programme to become General Practitioners. During this time they

spend the first two years on hospital rotation, working in different hospital departments,

and then spend their final year as GP Registrars in a General Practice surgery under the

supervision of a GP Trainer. The doctors in the group are all at different stages of this

process. The paper describes a weekly group meeting from the past year, in which the presenting doctor and the group struggle to understand and integrate their feelings about themselves as human beings together with their role and identity as doctor.

The initial response to the case is sympathetic but profound anxieties arise in the group when the presenting doctor mentions that her feelings and thoughts about this particular case have been designated "non-medical " by colleagues in a hospital department where she is on rotation. This judgement leads to a very concrete and technical discussion of the case by members of the group. This dynamic could subsequently be understood as a flight from the threat of judgement in medical culture about any acknowledgement of vulnerability, of "not getting it right" or not being the "right" sort of person to do this job. This fear of vulnerability is also reflected and contained in the interaction between doctor and patient, who, while ethnically and culturally different, have a shared, although unexpressed, understanding of the experience of belonging to stigmatised communities.

DISCOVERING MY WHITE MALE PRIVILEGE:
BECOMING AN ALLY – CONTINUING MY EDUCATION

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Abstract:

Being open to issues about diversity requires awareness of one's own cultural background and its influence and impact on becoming the person we are. For those of us who are white and especially white males and more especially older white males, this includes lessons on white male privilege and what these advantages are and what they mean, and how that can inform me and prepare me to truly understand what it means to be in someone else's skin. In this paper, I describe my own personal white privilege awareness journey including examples and challenges for Balint leaders to consider in their own personal explorations. I begin with a brief description of my upbringing, continue with identifying the key events that motivated my exploration of diversity issues, and then describe ways that motivation has continued to inform and support efforts at improving healing relationships in medicine and elsewhere.

White privilege? What did that have to do with me? I'm Jewish. I am a recipient and keeper of over 5,000 years of anti-Semitic history, i.e., discrimination because of my religious beliefs. This history is riddled with documentation of the significant disadvantages of being Jewish. Don't tell me about being advantaged! That's what I thought for most of my years. I have always been very sympathetic to and supportive of the struggle of African Americans and other minority groups, but I certainly included myself among the outsiders - the discriminated against. It seems a bit ironic because on the one hand, many (or most?) of my generation of Jews in the US wanted to blend in and to be accepted - even in the face of exclusion - while my parents' and grandparents' generations decried the loss of culture in the process of assimilation. While they, too, wanted us to have access to the golden doors of society and success, they found the compromises to achieve access challenging.

I grew up in a liberal upper middle class Jewish family, which was orthodox-in-name, in a small town in northeast Pennsylvania in the United States. My great-grandparents and grandfather immigrated to the US, escaping from pogroms in the Austro-Hungarian Empire before WW I. They had a significant influence on my religious upbringing, if only because of my loyalty to them.

With this background I formed a clear Jewish identity that was solidified during my college years by a 1968 summer trip to Europe and Israel that was sponsored by UJA. For three weeks in Europe we studied Hitler's early years in Munich, visited the concentration camps of Dachau and Matthausen, and welcomed Eastern European refugees at the train station in Vienna on their way to Israel. This was followed by five weeks in Israel, traveling from Jerusalem to Jericho to the Golan Heights, from Safad to Gaza and El Arish, and from Haifa to Eilat. I thought of myself **less** in terms of the advantages of my family's opportunities and **more** in terms of the discrimination I (and family members) experienced as Jews. I learned the stories of centuries of oppression. This included the impact of the Holocaust on 'my people' and how we continued to be the target of discrimination. I also had a detailed, multi-generation genogram with the blacked out symbols of family members who perished in the concentration camps. The last thing I considered was that I was privileged.

Totally separate from my developing Jewish Identity (I find myself knowingly smiling as I write this because of course, it's not totally separate - it is integral!) I began to learn about and eventually start a collection of artwork by Ben Shahn. He was born in Lithuania, emigrated to the United States as a teenager (probably about the same time as my great grandparents), worked as a printer and illustrator and eventually developed his own unique and readily recognizable style of social realism. I was attracted both to his imagery and to the very Jewish themes of injustice, discrimination and culture represented in his art. It was in London, at the end of that same trip to Europe and Israel, that I bought my first Ben Shahn poster - an image of a person with a quote from John Viscount Morley: "You have not converted a man because you have silenced him."

Many Ben Shahn books and lithographs later, and after I began my own business consulting practice in 2002, I was asked if I conducted corporate diversity programmes. These are popular training programmes in the United States, where businesses often have mixes of people who need to learn to understand each other better. Of course, the businessman in me said "Yes! I do that." And yet, the real answer was "No. I haven't done that yet." Even though I had some ideas and some great resources I could use to conduct a diversity programme, I needed more preparation. So I also attended several programmes about diversity and racism with the thought / intention of learning about activities I could use in my own work.

One programme in particular - Whites Confronting Racism - opened my eyes to the advantages I had without knowing it. I learned a lot about African American history and the ways white privilege and racism function at an institutional and societal level. In addition, I learned how White Privilege gives advantage, what Collusion is, and how Micro-aggressions have their impact. Most importantly, I learned to be open to hearing more about the ways people are treated differently based on skin colour and the daily indignities some people endure.

> Try to imagine walking on a street and regularly having people who are coming toward you cross the street before getting too close. Or walking on the street and hearing parked car locks click on as I walk by.
>
> Or, try to imagine being followed around in a convenience store. Or being told in your training as a store employee what the crime statistics are divided by race and told to watch customers of colour.
>
> Or, while driving, being stopped by the police for no reason other than to ask in an accusatory way: "Are you lost?" or "Do you know anyone in this neighborhood?"

It was a revelation to me to learn about these experiences of many or most black African Americans, of being followed by some clerks while in convenience stores, or being followed by police while driving and even stopped and questioned with no reason other than the colour of their skin, or suffering one indignity after another at school, or at work, or with 'friends' or their friends' parents. Notice that I said OR in between each example of an emotional wound - now change OR to AND! Don't think about all of these situations singly; think of all of them sequentially - one after another after another. I don't think I could contain the rage I would feel, and then I wonder what is the personal cost of containing that rage and what might be the impact on relationships in a society that systematically supports privilege. And then I wonder what it takes to trust others in a Balint group for a person of any marginalized group sitting with those with privilege. And finally, what are the implications for how I lead such a group? Examples of questions I ask myself as a leader include: When and how might I intervene in the group about an issue that relates to diversity? How might I detect a group member feeling excluded? Or, how might I tolerate or even manage a racially inappropriate comment by a group member?

None of these many examples happened to me just because I am Jewish, and clearly being a white male meant I never had to even think about these possibilities. But, if you are a person of colour in the US, being treated differently is always present. While I could never experience being a person of colour, I could choose to find some ways to become an ally to people of colour and other marginalized groups. At the time, I did not know what becoming an ally would look like.

Going through a personal crisis or two of my own added perspective and clarified my priorities about what is important to me in my life. One result is that I have become a bit impatient with too much of my own talk, lip service and not enough of my action. I suspect it is a bit of a reaction to my sense of having wasted too much time already being unaware of that white male privilege. Now, what I learned about injustice has stayed on my mind. In order to regularly remind myself of this useful impatience, I have hung three lithographs on the wall of my home office. Ben Shahn had created this suite of lithographs of three college students. They were killed in Mississippi while trying to register black voters during the Civil Rights movement in the US in the sixties. Michael Schwerner, Andrew Goodman and James Chaney were my contemporaries who gave their lives in 1968. I now envy the passion they had as very young adults and their willingness to act on their beliefs, while at the same time I mourn their loss. At that time in my life, I struggled with identity issues as well as priorities. I don't think I need to sacrifice my life; however, I do want to challenge myself to consider what I can do. My goal is to avoid complacency. I also fight my own tendency to be impulsive, so my hope is that I can act thoughtfully but with impact.

Part of the answer to this question about how to be an ally is to be willing to continue to do my own personal work, my self-examination, my willingness to write about what I'm learning, to challenge others to do the same, to teach through example, to be willing to have conversations about racial injustice with colleagues of all backgrounds. In all of this and more, I hope to be seen as an ally who is working for justice. I talk and write about white privilege. I explain that not agreeing is not the same as disagreeing, and passive collusion is collusion just the same. I look for opportunities to share what I have learned while accepting

we are all at different stages on our own journeys. I am one of two white male members of my state psychological association's Committee on Multiculturalism, and I feel like my perspective is valued because I am an example as an ally. I am also on the diversity committee of the American Balint Society, and I participate in diversity activities at our hospital and a medical school where I teach. Working with others has created opportunities to have conversations I would not typically have with like-minded colleagues.

There have been several other key moments that have had an impact on this awareness journey - I will share two of them. My first experience with diversity in the context of Balint groups occurred during my first four-day Balint leader training Intensive and before I had any awareness of myself as privileged. One of the members of my group was a female African American psychologist who was new to Balint like me. She was the only person of colour in the group. I recall hearing after the fact that she made a comment or two during the first case – I did not remember anything she said - but she did not say anything else during the next seven cases or during the debrief for each one. I never noticed - possibly being over involved with my own struggles understanding Balint - certainly not even considering whether she felt disrespected or struggled to find her place. I saw her early each morning in the hotel gym and we exchanged pleasantries, but we shared nothing more. Before starting with the last case on the fourth and last day, she asked to speak to the group. One of the other group members had checked in with her the previous day to ask how she was doing with this process. She reported that this had been one of the worst professional experiences she could recall - that she felt like her comment was totally dismissed, and she felt dismissed and marginalized. She considered leaving in the middle of the training. This was a surprise to me and I think to all the others in the group.

In hindsight, I certainly marvel at how clueless and insensitive I was about what it might have been like for a lone person of colour to be in such a group. While I don't attack myself for not engaging with her in the morning workouts, I still feel badly and wish I had a chance to apologize to her. I know that I am much more attuned to the impact of race and culture in healing relationships and in Balint groups than I ever was.

Another situation occurred at a residency faculty meeting where I thought a culturally inappropriate phrase was used to describe one aspect of our curriculum. At a minimum, the phrase was awkward, but we hold ourselves to a high standard, and I thought using it was an oversight and that my faculty colleagues would want to hear about it. Our meetings end with a closing ritual where everyone gets an opportunity to make a few comments about the meeting or anything else important to them that they wanted to share with the group. I volunteered to start. I emphasized that I know no one said anything intentionally inappropriate, but I thought we could be more culturally sensitive about how we use certain descriptive phrases, and I named the phrase I thought was inappropriate. As we proceeded around the circle, the next person passed. That is, they declined to speak, always an option at these times. Then the next person followed with another pass and another pass and so on around the room. I felt so alone, and I wondered if I did or said something terribly wrong. Fortunately, I have allies of my own whom I went to ask if I was out of line. They acknowledged feeling awkward the same way I did and struggled about what if anything they should say or not. They were supportive of my comments.

I have had several other occasions to discuss race in Balint groups and in Balint leader training. I am no longer hesitant to ask about race, to discuss race and to check in with any potentially marginalized person or to monitor their experience with Balint and with their

specific group. One challenge I have set myself now is how to invite group members to consider a particular cultural point of view that had gone without consideration rather than risk being heavy-handed with an interpretation of their oversight.

 Some of the accumulating lessons I am becoming aware of include:

- I have learned that I have much to learn.
- Understanding diversity is a never ending lesson in cultural humility.
- Diversity is just one part of having relationships, a personal part. We have to ask and we have to listen if we are to learn.
- Bias is no more than having a point of view. We all have one, so we are all biased!
- By definition, having privilege means being advantaged, AND it means others without that privilege are disadvantaged!
- Being an ally and writing or speaking up about one's beliefs is not always a popular role.
- I often revert to familiar positions of comfort. Then I remind myself of my intention to make a difference.
- Diversity is more than race! It is easy to focus just on race – we are such a visual animal that 'our sight impairs our vision.' I need to keep in mind diversity in age, ability, gender, ethnicity, and culture among others.
- People are more than their condition.
- In a really safe learning environment group participants can feel free to talk about race, religion or other personal qualities. They can tolerate a discussion about these qualities. Creating that safety requires vigilance on the part of the group leaders.

I will prepare a reading list for those who are interested in exploring this topic in greater depth. I encourage keeping a journal of your experiences with a particular focus on diversity awareness, and deciding to have conversations with colleagues about these same topics.

PRACTICALITIES OF DIVERSITY IN A BALINT SOCIETY

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Abstract of Paper:

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This paper discusses the need for diversity in Balint work, some issues that come with diversity, and the efforts of the American Balint Society to deal with diversity in a systematic way. It discusses parts of a report on the ABS Diversity Committee's first stage of work, and presents results for the first time of a survey of our membership, done to see where we are starting, what is the baseline from which we will work toward wider inclusiveness. The paper concludes with what we have learned from our process that may be of use to other societies.

At a very practical level diversity is necessary for Balint work. By diversity I mean otherness, lack of sameness, variety that allows us to look at or listen to each other and say, "Hmm. Not like me."

We need diversity in our health care practices to provide Balint cases. Diversity may be a part of every presentation. We present our cases in part because they include some element of otherness, something we had not considered or want to reject or do not understand. That otherness can be in ourselves, e.g. the doctor who surprised herself by revealing patient information. (Bachman, 2015) The otherness can be in the patient, e.g. the person suffering who refused treatment because of a belief system mysterious to us. (Knowlton & Katz, 2016) And otherness can show up in the relationship, e.g. where the doctor and patient got along well, the treatment was proceeding smoothly, and the doctor feared the feeling of friendship between them would be strained by the medical future he could foresee.

We need diversity within our groups. It is one of the elements that gives our work power. The presenter needs to hear something new in order to uncover previously unconscious material. The group members can let themselves be imaginative or offer thoughts freely knowing that other voices will add more and different pieces of the puzzle. Balint observed that becoming aware of diverse styles of treatment through his groups could have a maturing effect on the professional ideal. (Balint, 1972)

But it is too simple to say that diversity is defined only by otherness. In the United States we talk about diversity to refer to people who are identifiable as a group and who are underrepresented in some desirable arena: women in the board rooms of corporations; African-Americans among Oscar nominees. A white male colleague recently offered me this definition of the experience of diversity from the perspective of the privileged: These people are not like me and they want what I have.

Let me clarify. Somebody diverse by this definition may not want to take anything away from me. On the contrary, they may have great good will toward me. But the underrepresented may perceive the privileged as having something they, too, would like, such as respect, or economic security, or inclusion in a group, such as the IBF.

In the setting of a doctor-patient relationship, this "being different and wanting what I have" may involve the patient's sense that the doctor has an answer, or the power to provide relief, or the very keys to health itself.

Whether or not you are comfortable with that definition of diversity, I hope you will give it serious consideration. It reminds us of the possibilities of envy or jealousy, and loss inherent in dealing with

diverse people, and makes it plain we may have conscious or unconscious fears or guilt to manage when we move toward increasing diversity. What do we stand to lose through including others? If others want what I have, will I have to give something up to include them? Or will we have to make more of something, like respect, so that there is enough to go around? With more and varied influences will we become unrecognizable to ourselves?

This then is the tension surrounding diversity: we need it in order to function well and to grow, and it stirs up feelings which can be primitive and unwelcome.

This tension lends both importance and complexity to the work of the American Balint Society's Diversity Committee. I will report on its work and its process today, using in part a report about the history and work of the ABS Diversity Committee prepared for the *International Journal of Psychiatry in Medicine*.

The ABS Council voted to create its Diversity Committee in 2014:

> The process [of getting to that vote], though transparent, was not a simple straightforward one. The initial discussion at the ABS annual council meeting epitomized some of the ways diversity takes a back seat at almost every table. As in a Balint group itself, associations and tangents to the topic of a Diversity committee veered the conversation off the intended task of establishing such a committee. Fortunately, a champion of the cause persisted and the group was able to return to the focus sufficiently to accomplish this task. Now, although there were immediate volunteers to do [the committee's] work, the challenge was to set an agenda…..

Leaders of groups will recognize in our tangential, disorganizing process one of the forms defensiveness may take. The fears stirred by this topic tend to be uncomfortable to face and hard to manage and defensive behavior is common. We have noted repeatedly that diversity discussions may encounter subtle pressure to lose focus, even among people who want to have those discussions.

In fact, our first experience as a committee involved working to maintain and to sharpen our focus.

> The Diversity committee assembled quickly with a number of volunteers from the Society's governing council. Our initial conversations identified the wide range of discussions we might have and the need to narrow our focus in order to be effective. The first task we assigned to ourselves was to write a policy statement that would reflect the society's commitment to diversity in our membership and in our work. After creating a…draft..., we sought feedback from the membership…through our list-serve…[and] at our 2nd National meeting. [This] feedback…was incorporated in the final version….which….the council approved. (footnote text of statement)

Our early defensive tangentiality did not turn instanteneously into high functioning, easy, mature group process. We have worked hard to stay on task. Again, from the report:

> … the work of this committee has been made possible by the inherent nature of Balint groups - creating and maintaining an emotionally safe environment which allows committee members to express their thoughts and ideas freely, without censorship and in a spirit of exploring a topic that [is] inherently difficult because of its personal nature. As a group, only positive intent is assumed, and the pace of this work has been intentionally cautious, allowing sufficient time for ideas to emerge and, equally important, to settle in. This pace…managed by our co-chairs… has been an essential element of this meaningful and challenging work.

For example, the committee chairs decided very early in the process to meet twice as frequently as any other working committee. This gave us the feeling of having time to talk, time to work things through with each other, without losing sight, for too long, of the goal of taking action.

Perhaps I should say "actions" – plural. Everything seems to become plural when you are dealing with diversity. A group tackling diversity may act out the tension between integrity and accepting new influences that comes with this topic: by introducing more and more new elements or definitions or actions, the identity of the original focus may be lost or forgotten in a cloud of possibilities. Accepting new ideas must be balanced with returning to a core focus.

Thanks to hard work and good leadership we have kept that focus. The committee has begun the second phase of its work, recommending that each of the other ABS committees begin to define its own vision of inclusiveness and to figure out how to take steps toward greater inclusiveness. We are working to place diversity on the table for every policy discussion.

We have also pursued the important chore of conducting a survey of members to identify the degree to which we as a society already represent a diverse population. We realized early on that we did not know our baseline, and measuring that baseline has always been one of several tasks we knew needed doing.

In creating our survey we used the categories of diversity that we had been able to articulate in our diversity statement, including age, ethnicity, religion or spirituality, professional background, and national origin. Here is the picture which emerged.

We asked all our active members to participate. Of 295, 90 responded, a 30% response rate. Every question allowed people to write in their own answers or to check one of the options we offered. No question required an answer. Each question's results had an obvious cluster or two.

To quantify our results I used two measures from ecology: richness (R) to describe range; and a Gibbs-Martin index of diversity (D), which is appropriate for categorical data, to measure dispersion. (Retrieved from the internet, 2010)

Richness is often used as a simple count assessing how many species are in a given area, addressing the question how species-rich is that environment. Our provided categories (R1) represent our best guess about richness. The number of categories we ended up with (R2) is what's actually out there. Our guesses were pretty good: we provided 13 different degrees

someone might claim, our respondents added four more for a total of 17. We provided 6 options for ethnicity/heritage, and had only one added.

The only surprise was in the category of religion/spirituality. We provided 6 options and ended up with 26 different answers. The ABS has a very species-rich spiritual environment.

In contrast, of our 90 respondents only 54 answered the question about their age. All answers were optional, and age was by far the one most omitted. Perhaps we care about our spirituality, but think age is not important.

Professional Degrees
R1 – 13   R2 – 17   D = .2567

Ethnicity/Heritage
R1 – 5   R2 – 6   D = .3318

Religion/Spirituality
R1 – 6   R2 – 26   D = .7604

Sexual Preference
R1 – 2   R2 – 3   D = .1654

Abilities
R1 – 5   R2 – 8   D = .3170

Heritage/National Origin
R1 - 5   R2 – 9   D = .4774

"D", the index of diversity, is used to gauge whether a sample is well-mixed or not; it varies from a low of 0, completely unmixed (everyone in one category), to a high of 1, utterly mixed. Our highest diversity index was in the category of religion and spirituality.

Our lowest Gibbs-Martin index was for sexual preference, because of its very high mode for heterosexuality. We neglected to ask about gender and received advice from several respondents about how to do so in the future. They all recommended that we go beyond "Male" and "Female", at least offering "Non-binary" as an option.

What is clear from these results is mostly what we expected: our modal member is a Caucasian male, age 57, who is either an MD or a PhD, espouses Christianity or Judaism, is probably heterosexual and a US citizen and does not have any disabilities at this time.

We gathered this data to give ourselves a picture of the society and we shared that picture with our membership. Part of the Balint Society ethos is that self-awareness is valuable and that the collective can help support that awareness. In crafting our Diversity statement and in collecting baseline data it has been important to us to share our work as we go.

As a committee we return frequently to the question of what can be done next. We discuss our goals, our role in the organization and the strategies we might use to accomplish things.

The report on the Committee's first years of work concludes "[u]ltimately, we face the dilemmas of how to integrate a diversity perspective into Balint leader training, how to provide educational material for those already trained, and how to incorporate interactive activities that encourage inclusion for those still being trained."

We also have a strong champion for diversity in our new president, John Freedy, who has made it an emphasis during his tenure. He actively recruited people of varied heritage to serve on the ABS governing Council. That Council recently met in person to build cohesion among its many new and diverse members: the discussions about diversity were better focused, less defensive and inspired everyone to speak.

Looking at our current Council, you might say we have achieved diversity, but profiting from diversity in a Balint group or a society requires something more than diversity itself. Profiting from diversity requires connection. For instance, I mentioned before that frequent meetings helped the committee develop cohesion.

And connection is more than cohesion. By connection I mean the emotional bonds among people, and the ability within an individual to associate one experience or thought with another, to allow links. Bion established the foundational nature of this by observing attacks on linking that prevented learning from experience. (Bion, 1998)

We need connection in our practices. The connections with patients are still by far the most satisfying aspect of medical practice reported by primary care physicians in the United States. (Physicians Foundation, 2014) The connections within ourselves allow us to notice both our work satisfactions and our frustrations or mysteries.

We need connections within our Balint groups. Those connections result in change. A doctor presented a patient she was afraid of. When her closest colleague in the group was able to take the patient's point of view, she was very moved. She realized that she had not been thinking of her patient as fully human until she heard her valued friend speak for him. Individually, the presenter must link what she is hearing with thoughts and feelings that arise about her case, and the group members must create such links as well.

As leaders we all recognize the active linking that goes on in a high-functioning group, where people offer associations to each others' ideas, and where the atmosphere may be playful or creative while the focus remains unwaveringly on the case. While the governing of a society, or even of a committee, has distinctions from the leading of a Balint group, the parallels may be useful. As we become more diverse in our governing bodies and our societies, we can take as our goal the qualities of a high-functioning Balint group, which sees differences clearly and makes new links that may transcend those differences. In such a group the individuals have the support to do the work of tolerating and even appreciating diversity and the connectedness to do the work of allowing or even creating inclusion.

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Ascona Prize Essays

MEETING MARGAERY

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I knew instantly which student-patient relationship I would discuss and reflect on in this paper. Not the patient I've been the most moved by- not an account of the first death of a patient I encountered, of the pancreatic cancer patient I visited every day until I found her bed empty, not the skeletally thin child silently screaming in pain I met on an overseas elective, her parents

desperately searching the doctors eyes for good news that was never coming. Not the first birth I witnessed, blown away by the power and vulnerability of life, not the intellectually disabled child I sat next to day after day watching the fish tank together on the pediatric ward, wondering when his mother would come and visit him.

Over the past few years of medical school I have met many patients that have moved me and impacted the way I approach medicine and life in general. I chose this particular patient because the relationship we built was complex and different, lacking the heroic and exciting aspects of Medicine, but special and valuable in its own way. I chose this patient, because to this day, the experience challenges me and makes me feel uncomfortable. This reflection is a way deconstructing these feelings and discovering how I can translate my experience into my future practice in Medicine. I will discuss this relationship in a chronological method, split into ten parts, and critically reflect on events as they arise.

Part 1: Meeting Margaery

Margaery was a 69 year old female admitted to hospital with a small bowel obstruction, on a background of multiple comorbidities including hypertension, COPD and renal carcinoma. She was intellectually disabled, with cerebral palsy and foetal alcohol syndrome. Her past surgical history was significant for appendectomy and hysterectomy. On admission to hospital she was managed medically with IV antibiotics and nasogastric decompression for three days, before escalating to surgical intervention with a small bowel resection and ventral hernia repair. Over her approximate 10 week hospital admission, she returned to theatre multiple times for debridement of pseudomonas wound infection, a mesh infection, abscess formation, wound dehiscence and multiple surgeries for vacuum assisted closure. She also suffered other complications including deep vein thrombosis, cellulitis and urinary tract infections.

I encountered Margaery for the first time on a surgical ward round with several other students and a group of doctors. She was in the window bed of a four bed room and all the other patients had their curtains drawn. She was obese, with greying dark short curly hair, flushed cheeks and beady dark eyes. She looked washed out and uncomfortable in her white hospital gown and was groaning about being hungry. I could tell by listening and observing from the back of the group that she had some form of intellectual disability. Some doctors looked at her with distaste, others with pity, only one stood out to me as taking a particular interest of listening to her story. She was what we labelled as a "poor historian". Being a "poor historian", having an intellectual disability, and a medical chart with previous admissions hundreds of pages long,

meant that we didn't spend much time at Margaery's bedside. As we rushed to the next room in the flurry of ward rounds, I looked back and saw Margaery's cheeks wet with tears, she was sniffling and still repeatedly asking for food. She reminded me of a small child- confused and vulnerable. I felt a wave of pity for her.

I'm ashamed of the initial thoughts I had of Margaery. But nonetheless, they were the first, judgmental thoughts that invaded my mind. I felt sorry for her, but there was also an element of distaste and disgust. She was obese and poorly groomed, and "whinging" about being hungry. "How could she let herself get that way? Why can't she understand that she's unwell and can't eat?" were questions running through my mind. Does that make me judgmental? I know that people are impacted by circumstances and environmental factors outside of their control, and yet those ugly thoughts were still the first ones to come to mind.

A large part of medicine is learning how to efficiently make judgement based off your observations of a patient. Judging when someone is well versus unwell, when you need to escalate care, when you're out of your area of expertise. One of the most important aspects of examining a patient we are taught in medical school is doing an "end-of-bed" inspection- where we specifically comment on the patient's body habitus, their hygiene and mental status. There has to be a difference between making judgement, and being judgmental, yet I've found the line dividing them increasingly blurry. Particularly with patients like Margaery who *are* obese, have poor hygiene and are intellectually impaired. I feel like these observations, although often important in formulating diagnoses, hindered Margaery's care. She was repeatedly almost ignored on ward rounds, it was always her surgeries that were pushed to the end of the day, or the next day, and her admission lasted 10 weeks due to the multitude of complications she suffered, many of which could have been prevented. It seemed like these particular qualities translated to a poorer level of care, compared to a patient in an equivalent situation, who wasn't obese, who had good hygiene and didn't have an intellectual disability.

Is it our role as doctors to decide how deserving patients are of our care? Of course we need to triage patients based on how unwell they are, and ensure that they are seen to with appropriate urgency. But what other factors come into play? Health literacy and the demands of the patient? A patient who smokes versus one who doesn't? A patient who takes drugs versus one who doesn't? A patient of normal weight, versus an obese one? A patient who is pleasant and kind, versus a patient who is volatile and angry? There are many factors that influence, often subconsciously, the care we provide for patients. It is important to identify and recognize these

factors, so that we can work towards consciously ensuring they do not bias our care. It is not our role to place value on our patients.

So in answer to my question- yes, I was being judgmental of Margaery. I am human- such thoughts may arise again and future patients may evoke similar reactions. The key is identifying these judgmental thoughts for what they are and employing strategies to ensure they don't negatively impact the care provided. Being aware of the concept of transference is relevant here- unconsciously transferring feelings or attitudes from previous situations or interactions to the present. I had only just met Margaery, but attitudes and feelings I had from previous experiences surfaced and shaped the impression I made of her.

Part 2: A slightly forced relationship begins

It was the end of my first week on surgery that my relationship with Margaery really started. And I admit, not by choice. We did a weekly teaching round at my hospital, where all the students picked two patients to present a brief verbal handover to the consultants. It was a great learning opportunity, but also one of the most nerve racking experiences of medical school- you needed to know everything about that patient for fear of not knowing an answer to a question! We'd stay late the night before perfecting our cases, and arrive in the early hours of the morning to find out if anything had happened overnight and record the most recent observations. You really took "ownership" of the two patients you presented, and if they stayed in hospital, you would follow their case until they were discharged.

I was scrubbed into surgery on the day of allocation, so had last "pick" of patients- the uncomfortable and complex patients were always left until last. Sure enough I had Margaery. I sighed in frustration. I was tired from standing all day, the rush of adrenalin from answering several questions correctly in theatre was quickly fading (oh, the exciting life of a medical student!), and I just wanted to go home to eat chocolate and sleep. Instead, I reluctantly pulled out Margaery's multiple charts and started rifling through them. There was plenty of writing in those charts, but weeding out the relevant information was challenging- "fetal alcohol syndrome", "intellectual disability", "poor historian", "emotionally labile", "multiple comorbidities", "complex social issues", "acopia" were common phrases. Her medical and surgical history seemed to differ from entry to entry. Around 7pm that night I went to go and chat to Margaery. It wasn't much of an interview. She told me a similar disjointed story to what she had told the emergency and surgical doctors. I could tell she was sick of talking about it, and still preoccupied with getting some food. I tried to explain, to no avail, why she couldn't

have food. I left the hospital feeling pretty hopeless, worried that my case presentation wouldn't be up to standard the next morning.

I thought of Margaery that night. I thought of her hungry and confused in that hospital bed. I realized I could have approached my interview with her that evening differently. Instead of again imposing rules to her of no eating, I could have empathized with her hunger. Empathized with the frustration she must be feeling sitting in that bland hospital room with no one to talk to, only exacerbated by her stomach curling in hunger. But I had been more focused on getting home to eat dinner and worried about my case presentation to think about how Margaery would be feeling. I felt sorry for her and decided to make more of effort to talk to her tomorrow, maybe try and cheer her up somehow.

But the next day was a mad rush of sweaty palms and racing hearts, as we presented our first handover to the consultants. I was more preoccupied with remembering my spiel about Margaery, then actually checking in as to how she was going. I remembered her bloods, her observations, her fluid balance. I found myself using the terms "poor historian" and "acopia" I'd seen littered again and again through her notes. And yet I forgot to mention she was in pain and that her belly was still very sore. I certainly wasn't practicing patient-centered Medicine- I was practicing what I would coin "medical-student centered medicine", which involved presenting as efficiently and quickly as possible, while covering enough pertinent information to avoid questions. I put my own interests above Margaery's- I reduced her to a set of numbers rather than approaching her as a person and advocating for her best interests. This tendency towards "clinical reductionism", reducing patients to bodies with parameters you can record and monitor, is convenient and time efficient. But it is poor Medicine and results in poorer quality care. I find that reminding myself to treat patients the way I'd like a family member to be treated a useful strategy to ensure I am practicing patient-centered, holistic care.

Part 3: Margaery's Surgery

Margaery went into emergency surgery the next day for a laparotomy, including a small bowel resection and ventral hernia repair. I scrubbed into the surgery and assisted. This was towards the start of my surgical rotation and everything was still new and fascinating to me. It was like clockwork for the surgeons and anaesthetists in that theatre. They had some music playing and were bantering about the weekend's football game as they operated. Margaery didn't really seem to exist to me in that theatre. Sure she was there, under the plastic and asleep to the world. But I was completely caught up in this foreign environment, out of my comfort zone,

concentrating all my energy on avoiding contaminating anything and racking my brains for answers that just didn't seem to be surfacing.

I can draw parallels between this experience and what it may have been like for Margaery being admitted to hospital. In this new, intimidating environment where you don't belong, surrounded by people who are just going about their days without a second glance at you. Feeling alienated and alone. And then while coming to terms with all this, being asked perfectly formed questions by the consultant, which you just don't know how to answer. Finding this common ground, whether it was real or not, made me feel like I could relate more to Margaery.

Margaery was admitted to ICU post-surgery. Visiting her in ICU was a confronting experience. Tubes running from every orifice, machines attached at every limb and Margaery's frightened expression beneath it all. I began to wonder what would happen if things made a turn for the worse- who would speak for her? Who would advocate for her? I didn't know.

Part 4: Rapport Building and Weather Reports

The next time I saw Margaery was when our weather reports began. She had been discharged from ICU, but seemed to be making a slow recovery from the surgery. I could tell she was in pain, although she wasn't complaining about it as often. She seemed to have resolved to endure it- perhaps it had become normal for her. "Good morning Margaery!" I exclaimed cheerfully as I knocked on her, now single, room. It was a particularly beautiful day. I'd been for a swim that morning in the ocean and watched the sun rise, and felt invigorated by its beauty. I was also acutely aware that Margaery could do no such thing trapped in her hospital bed. I asked her if she'd like me to draw her curtain back and she agreed, so I pulled them back revealing the large glass window behind it. I described to her how stunningly blue the sky was, how the clouds floated prettily in all shapes and sizes, the sun beamed happily on the bright green grass, alongside the river that flowed glassy and clear.

We built our relationship on those weather reports. From that day on I would come in early every morning and deliver them to her. The rain beating down on the pavement forming treacherous puddles, and the river overflowing. Or the wind blowing forcefully, the ocean furiously pounding on the shore just beyond the hospital. During those reports I like to think we both escaped that hospital room momentarily. Slowly we started to talk more about other things. Her home- she lived on her own, she told me she liked it that way and "wouldn't move into a home", almost crying just mentioning it. She had some social services in place- meals

on wheels gave her food, and a cleaner came once a fortnight. She loved to read the newspaper – she read the newspaper every day, and also liked to read magazines. She loved flowers, particularly yellow ones. She had a daughter who she hasn't seen in many years. Both her parents passed away a long time ago. She was married once, but her husband was no longer in the picture. She dreamt of finding another true love. As the days passed, I found the judgmental thoughts I originally had of Margaery vanished. They were replaced by thoughts about what a gentle and kind hearted person she was, empathy for the pain she was experiencing and hoping she would recover quickly.

Part 5: Margaery*'s Visitor and a Birthday*

Margaery returned to surgery sometime the following week due to wound dehiscence and infection. This time I was less in awe of the cutting of skin and fresh blood, and more aware of the person under the plastic. Of Margaery lying there unconscious, her life in the hands of the anesthetists and surgeons. The startling realization hit me that there was no one in the waiting room worrying about Margaery, no one waiting for her on the other side for when she woke up.

Margaery was in hospital about 4 weeks before someone visited her. A friend from down street who I got excitedly introduced to when I popped my head in that day. Margaery talked about it for several weeks to come. I'm sure that lady had no idea what an impact that 15 minutes of her time made to Margaery.

One day during her admission it was her 70th birthday. The nurses gave her a box of flowers they'd been given by another patient's family. My hospital partner and I made her a card and went to say happy birthday before ward rounds. She was ecstatic and cried with appreciation, exclaiming that it was one of the best birthdays she'd ever had. No one else came to visit her that day- no member of her family, no friends. She turned 70 virtually alone with someone else's flowers and a handmade card from two medical students.

I called my Mum that night and cried. The best birthday this woman had had in 70 years, was in her 4th week of admission to hospital, in which time she'd had a single visitor. I felt desperately sorry for her and the crushing loneliness that enveloped her life. I felt angry at the injustice, at the unfairness of her life. That her mother had drunk through pregnancy, that her childhood had been a cycle of relative poverty, abuse and vulnerability and that because she

had an intellectual disability, her ability to advocate for herself was compromised, not heard or ignored.

I know there are people "worse off"- people in that same hospital dying, people losing loved ones, people "worse off" than not having visitors on their birthday. And yet it really struck a chord with me. I felt like Margaery had been cheated of something I'd taken for granted my entire life – of having people to love you and validate your existence. And yet she cheerfully didn't seem to realize anything was missing. I knew that she could have been taken advantage of multiple times without even realizing it. She was more vulnerable than most people, more in need of a loving family, of someone to advocate for her than others, and yet she had no one by her side in her time of need.

Part 6: Margaery discloses sensitive information

I can't remember the exact details of this- it's a bit of blur, something I have locked away in the back of my mind. One morning in around her sixth week of admission, Margaery casually mentioned to me that she'd been raped twice- once as a 14 year old and once as an adult in the context of domestic violence. She told me she still occasionally attends a DV group and a lady from a support group calls her on the phone every now and then to check in on her. She was her usual cheerful self while telling me this and didn't seem to expect me to say anything. So I just sat there and listened while she talked about it. I didn't know how to respond. I didn't know if I should encourage the conversation and ask questions, or if I should leave the room and get a doctor or nurse. I just didn't know. I felt out of my depth- she was saying these words to me, the impact of them slowly rearing its ugly head at me. I felt rage swelling up inside me- anger that Margaery had experienced such a violation, that her vulnerability had been taken advantage of in such a horrific form. And yet she was discussing it the way you'd talk about what you were eating for breakfast.

We've had communication workshops on breaking bad news. But I hadn't had a workshop in receiving "bad news" from patients, particularly such sensitive information. I felt helpless- she was telling me this ground breaking information, a kind of conversation I had never had before, and yet I couldn't do anything. I couldn't even think of any words to say to her apart from gently taking her hand and asking "are you okay?". She said she was fine and we went back to talking about the weather.

With this information I had a heightened sense of her vulnerability and a sense of responsibility to protect her. I felt that while she was in hospital she was in a haven of relative safety, but I worried about her being discharged back into a cruel world ready to take advantage of her at every turn. I also felt like I was carrying a burden- I had a feeling Margaery hadn't shared that information with anyone else on this admission. I didn't discuss it with any of my colleagues or doctors, I kept it to myself. I'm not sure if I should have handled that side of the situation differently- I knew that she had disclosed this information before, but perhaps it might have been important for the surgical team to be aware of in their care of her. She had made requests during her stay only for females to do certain procedures on her, but in a team that was largely male dominated this wasn't always possible. These requests suddenly took on a whole new meaning.

I ran many scenarios through in my head as to what I should do. But I overwhelmingly felt like I was "just" a medical student. I didn't have any power to make a difference to Margaery's situation. I couldn't right the wrongs that had happened. I couldn't prevent her from being wronged again. This sense of powerlessness led to me to shutting out the information Margaery told me and trying to forget she told me. She never brought it up again, and I never mentioned it. It was like our conversation had never happened.

It's only in hindsight and deconstructing this experience, that I realize I perhaps had unrealistic expectations of I how should have responded in this situation. Or what Margaery expected of me. I don't think Margaery expected anything of me other than to listen. Although at the time I felt powerless and like I could do nothing- I *had* done something by being there with Margaery, and listening to her. By building rapport with her to the point where she felt she could share just private information with me. I have slowly come to appreciate the power of listening to people. Of actively listening to people. All the things I'd been taught in communication workshops about active listening seemed to subconsciously switch on in that conversation I had with Margaery. I was leaning forward in my chair beside her bedside, decreasing the distance between us and making eye contact with her. I sensed a need from her for human touch, so I took her hand at the end, physically bonding us in the information she had just shared. I said only three words in our interaction, and yet perhaps they, combined with such minute actions of listening, were enough to show Margaery that I cared.

I learnt several important lessons from that experience and reflecting on it. Often in medicine and in life, there are no "right" words. No words that can do justice or give adequate comfort

to what people go through. Sometimes, all you can do is be present and listen. That is one of the very special privileges we have in Medicine. The privilege of being by our patients' sides, people who are relative strangers to us, but who open up to us about their most private and sensitive aspects of their lives.

I also realized that the feeling of powerlessness I experienced with Margaery is one I will become familiar with in medicine. It is an uncomfortable feeling, a feeling that doesn't seem to belong in an era of medicine that exudes control. We have technology that allows us to monitor every parameter of a patient's body, machines that keep people alive when they would otherwise be dead, cures to cancer that were a death sentence twenty years ago. Doctors seem to have a duty and expectation to eradicate human suffering through any possible means. But there will be situations where our ability to do this is limited. I will be in situations that are out of my control, patients will die in my team's care, in my care. Future patients will disclose accounts of suffering including domestic violence and abuse.

Perhaps part of the key is reframing what we define our "powers" as doctors are. I may be powerless in saving a patient's life, I may be powerless in alleviating certain forms of suffering, but I will always have the power to listen to my patients. I have the power and privilege of building rapport with them and empowering them to a position to share such information if they choose.

It also hit me how easily that conversation could not have taken place. That I could never have known about that part of Margaery's history. I got to know Margaery more than most people get to know their patients, owing to the length of her admission and relative free time on my behalf. Yet I still saw only the briefest snapshot of her life. And my snapshot of her life is shaped by my own judgements, past experiences, values and beliefs. Margaery isn't just a patient in hospital, but a person living her own life that I know nothing about. It made me really appreciate the importance of empowering patients to make their own decisions and upholding their autonomy wherever possible. At the end of the day those decisions impact their life when they leave hospital, not mine.

I also learnt something about myself- which is that I have a tendency to lock away difficult and challenging experiences, whether personal or someone else's shared with me. That has been my way of dealing with things- I don't know how to process what I've experienced and I don't want to burden someone else with it, so I try to forget about it. It's only when something forces me to think about it, that I really begin to deconstruct and process my experience. I had this

realization recently, when I got very upset in a simulated advanced life support scenario that resulted in our simulated patient dying. I had to hold back tears and I felt overwhelmingly guilty. I realized during debrief afterwards, that the scenario evoked such a strong emotional response because it reminded me of a real one I experienced on placement earlier that year. I was the only student in a rural setting, and was involved in my first cardiac arrest late at night. Our relatively young patient died despite the doctor's frenzied efforts to save him, his wife screaming hysterically at the bedside. I left the hospital alone that night back to my student accommodation and never spoke about it again, until that debrief after the simulated scenario. For me, this reflective essay has served a similar purpose to that debrief. Many tears have been shed thinking about Margaery and deconstructing my relationship with her, searching for the right words to articulate our story. I've realized the importance of debriefing and reflecting, particularly after challenging situations. That it is beneficial not only to myself and improving my future practice, but also to my colleagues, and ultimately to patients and their families. Making the effort to regularly reflect and engage in debriefs are strategies I will try to implement the future.

Part 7: Professional and personal boundaries

There were several experiences I had with Margaery that made me question the professional boundaries between us and my role was as a medical student. Our time spent together increased over the duration of her admission- my morning drop-ins extended to include afternoon visits, where I would take her for walks up and down the corridor. The nurses and doctors knew how familiar I was with her, and would often call me in to help with certain procedures or scrub into her surgeries.

I came into her room one morning to find her crying because the man with trolley had forgotten to give her the daily newspaper. She read the newspaper every single day, and such a disruption to her routine, and being seemingly forgotten, made her very upset. I offered to go and track him down to fetch the newspaper for her. I couldn't find him, and found myself downstairs in the hospital news agency buying her a newspaper with my own money. I remember feeling slightly uncomfortable as I passed over the two dollar coin for the newspaper – this was no big deal I assured myself- just a $2 newspaper to keep her happy. I didn't tell her I bought it, I just handed it over and went about my day. But I felt like I had crossed a line. Although it was of no monetary significance, it represented a personal investment in Margaery I hadn't

acknowledged until then. I realized that this personal investment had the capacity to impact the care she was receiving.

There is an inherent power imbalance in a doctor- patient relationship, where the patient is vulnerable. The giving of "gifts" or favours for patients, can change the power dynamic in the relationship and set certain expectations that may impact the therapeutic relationship. For instance the patient may feel as if they "owe" the doctor something, and the doctor may lose their objectivity towards treating the patient. I certainly felt like I had lost my objectivity when it came to interacting with Margaery - I would preference her over other patients I had to present and spent a lot of time at her bedside. Although this wasn't a concern as a medical student, as a doctor it would be poor practice and unprofessional to give preference to patients in such a way.

I also found that Margaery would give me preference – she would insist on giving me several attempts at securing cannulas, and would always ask that I scrub into her surgeries. She refused to get her PICC line in unless I accompanied her. This was a big learning curve for me. I was acting with good intentions spending time with her and buying that newspaper for her. But I think I did cross a professional boundary, in that her care was compromised in some respects because of our relationship. It made me reflect on my tendency to try to "save" people from misfortune. It's part of what initially attracted me to medicine- the opportunity to help people in need every day in such a personal way. I think part of what drew me to spending so much time with Margaery, was *because* of her vulnerability. I felt like I could help minimize her vulnerability by spending time with her and building rapport with her. It's hard to come to terms with the fact that my good intentions had the capacity to be detrimental to Margaery's care. Having this perspective and self-awareness will be important in my future practice in Medicine. To maintain such perspective, it is critical to reflect on what my role as a medical student or doctor is- and that is not to be a patient's best friend. It is to provide optimal care to the patient as a member of a healthcare team- part of this care includes rapport building and demonstration of empathy, but optimal care also depends on remaining objective towards the patient.

My investment in Margaery also took a personal toll. I would stay extra hours, occasionally late into night for her procedures or surgeries. I was thinking about her a lot out of hospital hours, hoping she was okay and worrying about her future after discharge from hospital. My mother knew all about this patient because I talked about her so much. She would gently

suggest that perhaps I was spending a bit too much time with her at the hospital, and that it wasn't my place to be worrying about her. As the weeks went by I began to realize that perhaps my mother was right (they always are aren't they). It took someone removed from the situation to point this out to me- I was in so deep I had lost perspective. It made me appreciate the need to have a support network outside of Medicine- of having family and friends who bring you back to earth and remind you that the life you are living extends outside of hospital doors. I also realized that having such a personal investment in patients is simply not sustainable. How can you possibly function as a doctor if you're taking on the emotional burden of all your patients? Maintaining professional boundaries with patients is not only integral to the provision of optimal care of patients, but also in the mental health and avoiding burn out in doctors providing the care. I've thought of several strategies I will try to implement to prevent myself from becoming emotionally invested in patients in the future. This includes continuing to identify the "type" of patient I am prone to be emotionally invested in – those particularly vulnerable people, discussing with a colleague or boss when I feel like my professional boundaries have potential to be compromised, and approaching the patient in a team setting where possible rather than individually. I will also continue to value and foster my support network outside of Medicine.

Part 8: Margaery goes home

It was strange witnessing Margaery change over her ten week admission in hospital. She went from being this frustrating, complex patient who whinged about wanting food and going home, to a woman I visited every morning to discuss the weather with, and had become very fond and almost protective of. Towards the end of her stay, she didn't want to go home- she wanted to stay in hospital. Perhaps she didn't change at all- perhaps it was more a change in my thoughts and attitudes towards her. As her discharge date drew closer, I found myself withdrawing from her more and more. I would pop my head in occasionally, but I stopped visiting her every morning. I knew she was hurt and confused by this change in routine.

I think the way I acted was a protective mechanism. I knew seeing Margaery leave would be upsetting. Not only because I had become quite the expert at weather reporting, but because I was scared of what awaited her in life outside hospital. The Allied Health team had done a great job implementing more supports and visiting her house to make it as safe as possible for her on discharge. Yet I still worried about her ability to cope alone after so long in hospital, I

was worried that she'd be taken advantage of again, that she'd be hurt, that she'd become unwell again.

It was difficult to accept that all or none of things could happen to Margaery - and that they were completely out of my control, and quite frankly not my business. This person who I'd shared so many vulnerable moments with, who had shared with me such personal information, who had laughed and cried with me, was leaving. It was heartbreaking thinking of her sitting in her arm chair at home, with her newspaper and magazines, all alone. Of the many people who would look at her with judgemental eyes, the way I initially had. These feelings again made me again realize the boundaries of being a doctor. In the scheme of things, we have such brief interactions with so many patients- these interactions may impact a patient's day, their week, or their lives. But regardless of this, when a patient is discharged from hospital our relationship with them ends. The responsibility for their health returns solely to their hands, and our ability to impact it is gone. It also made me again reflect on the importance of not becoming so emotionally invested in patients. I felt awful knowing I was upsetting Margaery by no longer visiting her every day- I had set this as an expectation which I was now failing.

I went to say goodbye to Margaery with my hospital partner that Friday. She insisted on taking a photo of us both on her disposable camera, and was all excited like she was going away on holidays. I wonder sometimes if she ever printed that photo, if I ever crossed her mind again. The following Monday I found her bed occupied by a stranger, with nurses bustling around her and the whiteboard at the end of the bed wiped clean of the name "Margaery". It was like she was never there, and the ward carried on as usual. I tried to imagine Margaery at home going about her Monday morning, but I couldn't – to me she'd always be the patient in that bed who I delivered weather reports to.

Part 9: Lessons learnt

My encounter with Margaery taught me many lessons- about Medicine and about myself. First and foremost, I realized how poorly equipped I am to interact with patients with intellectual disabilities. I've left this part to last, because even now I am unsure how to discuss it. I'm not sure of the correct terminology to use, I'm not very knowledgeable about the spectrum of intellectual disabilities and what impact this should have on the way I provide healthcare. I know all people are different, and it would require a case by case approach, but there were

some challenging aspects to Margaery's care involving consent and articulating what her wishes really were. Do I think Margaery would have received better care if she didn't have an intellectual disability? The sad truth is I really do. I think her admission would have been shorter, I think she would have suffered less complications, and spent less time in theatre.

I feel like our public medical system is not designed to cater for people with intellectual disabilities. People who require a lot of extra time and support, who have lower health literacy and are unable to always advocate effectively for themselves. This extra time and support did not seem to be available on the surgical ward- time was precious, the surgeons spent most of their time in theatre and Margaery became a piece of the furniture, often only getting their attention at the last minute when someone realized she was unwell. The system favours those with higher health literacy, who can voice their wishes and demands, giving doctors a heightened sense of accountability. It's easy to see how a vicious cycle is established.

I think medical students could benefit from training specifically in interacting with patients with a disability. We had a disability seminar last year, which was very helpful, but focused more on Carers, rather than providing frameworks or strategies to working with people with disabilities. I have attended multiple camps with children with intellectual disabilities over the past 7 years, and yet I still felt completely out of depth in the healthcare setting. Providing communication workshops and lectures specifically geared towards talking and interacting with patients with intellectual disabilities, and doing some kind of community placement, would be beneficial.

I came to realize what a privilege it is to practice medicine- to share with people some of the most vulnerable moments of their lives. I learnt the importance of practicing patient-centred medicine- of avoiding the tendency to reduce people to numbers and trends, and treating them as people with individual experiences of illness. All the communication workshops I had on demonstrating empathy and active listening suddenly became very relevant throughout my journey with Margaery. I also had a glimpse of the challenges I may encounter in medicine-maintaining professional boundaries, avoiding emotional investment in patients and the limitations of the role of a doctor.

Throughout this experience I also learnt a lot of things about myself. It hit me hard what a privileged life I lead. Not just in the sense of practicing medicine, but of being in the position where I can study medicine. I received a high quality secondary education, I have a relatively wealthy family who support me at every turn- who lent me a car so I could commute to the

hospital, who help me financially when I need it and who are always there to pick up the phone and give me advice or comfort. From my experience, medical students and doctors generally come from relatively privileged backgrounds. This is important to recognize, as such privilege shapes one's views, values, beliefs and attitudes and can pose challenges when interacting and making judgement of patients who aren't from such privileged backgrounds.

I also learnt the importance of self-care, reflection and mindfulness. I've found that for me these three concepts are interlinked. I dropped the ball with my own self-care over the course of my interaction with Margaery. I became emotionally invested to the point where my own emotions and mental health were suffering. It's really only been in hindsight, that I can appreciate the importance of stopping to regularly reflect on my experiences, and taking time out to exercise mindfulness, as steps to optimize my mental health.

Margaery taught me the importance of building rapport. Perhaps I overstepped the line, but I still can appreciate the importance of spending time with patients and building their trust. It communicates to patients that they are valued and respected, and paves the way for open communication. After my encounter with Margaery, I made it a habit of mine to always asking patients what their understanding and concerns were at the beginning of interviews. In the acronym we were given by the medical school for history taking these two questions are at the end of a list of eight other questions, and would often be forgotten or cut out due to time constraints. I realized that empowering patients to voice their concerns and understanding as soon as possible is integral in building rapport from the beginning and ensuring delivery of optimal care.

Interestingly enough, despite many hours spent describing weather patterns, I learnt a lot from Margaery in terms of medicine content. I knew everything about her surgeries, the complications she suffered, the medications she took and the comorbidities she had. When questions came up in exams related to any of these topics, I could picture her and figure out the answer. Many of my professors have told me that everything you need to know is in your patients, and I finally understood this concept.

From my experience, the main ways in which future medical training could enhance states of awareness, include promoting regular reflective writing, regular debrief opportunities and including reflective components as a section in case reports. Continuing to expand communicating workshops, to include some geared towards receiving "bad news" and working with patients with disabilities would also be useful. Implementing ways in which patients can

give feedback about the care they received could also promote self-reflection and improvement among doctors.

Part 10: A Finishing Note

Margaery was readmitted to hospital several weeks later. I heard her booming laugh from the Women's ward and heard a bunch of students talking about her unkindly in the tearoom. I was onto a different rotation by that point and I never visited her, although I would look up her notes occasionally to see how she was going. I knew that our relationship had come to a close, and needed to stay closed.

I still think of her from time to time. Sometimes on a beautiful evening on the beach when the last light is fading beyond the horizon, sometimes when I'm surrounded by my family chatting and laughing. She's a patient who I will always remember and think back about for many reasons. She taught me more than I could have ever imagined, and she challenged me and made me re-evaluate myself as not just a medical student and future doctor, but as a person.

Names have been changed.

FROM REGRESSION TO PROGRESSION:
A MEDICAL JOURNEY TOWARDS A PROFESSIONAL IDENTITY.

Nuphar Vinegrad

I met Aaron in my first week of surgery clerkship. He walked in and quietly sat down on a chair in the middle of the crowded room. He had brown hair and looked young, in his mid-

thirties I would guess, thinner than most people, perhaps as thin as someone who exercises regularly. Then my eyes moved to the left - his wife was with him, she had blonde hair and brown eyes, she was tiny, fragile and very kind looking.

It was a pre-op meeting, one in which the surgeons explain to the patient about the procedure he is about undergo, examine him if needed, and then the patient asks some final questions and signs the consent form. There were four surgeons present, myself and eight other students from my class, all of us in the 5th year of medical school. Some of us sat on chairs, some on tables at the back. The room had no windows as it was built underground, so that it could be turned into a shelter in a time of need. It was around noon and Aaron and the other patients had been waiting outside since the early morning.

The patient who came in before Aaron was a 17-year-old teenager with an inguinal hernia. He was to be examined behind an improvised drape, placed at the side of the room, that hardly gave him any privacy. "You!" one of the surgeons pointed at me and said: "Come and show me how you examine an inguinal hernia". I angrily took a glove and walked towards the boy. "Do you mind if I take a look?". Next, I turned to the surgeon who pointed at me and said: "Show me how!". The surgeon examined the boy again and again, I also had a turn, the boy's face turned red and very quickly after, the examination was finished, he signed the consent form and ran out of the room.

Aaron's pre-op meeting started vaguely for me, and as I hadn't seen his file beforehand I couldn't have known his diagnosis. He slowly but essentially told us how he went to see a doctor because he had heartburn. He explained about the treatment trials he had with PPIs and finally, how IT was discovered during endoscopy a few months later. "Are you going to leave a part of my stomach?" he asked, nearly begging. "Yes! We will leave a small part", the surgeons reassured him. The other question that was already in the air, hovering over us, was never asked. The doctors did not approach that subject, and neither did Aaron or his wife.

The week that preceded this meeting was the first week of the clerkship. The other students and I joined the doctors round in the ward, entering each room in a big group. The doctors efficiently and indifferently examined patients, changed bandages, pulled out drains, moving quickly from one room to the next. On one of the days I asked an intern after a bed-side procedure whether it is acceptable to administer pain killers before such a procedure. He replied that it is possible but in the reality of the crowded ward it was not done routinely. Every round

was accompanied by heart-tearing gasps and uneasy sights, as patients complained or issued shrieks of pain.

Aaron's surgery was two days after my initial encounter with him. I washed and wore my sterile gloves, then I placed my hands on his body, trying not to interfere. Before I walked into the operating room I saw his wife outside again. As Aaron was being transferred into the OR she was making her way to wait outside. "I saw you before, do you remember?" I asked, feeling the need to approach her just before she left. "Yes", she replied. Her eyes moved quickly as she examined me. I told her that I was going in with him, she nodded and gestured a smile locked with an anxious expression.

The surgery was long; I was sweating inside my sterile outfit as I was holding some of the equipment used during the surgery. My head started spinning as I heard the surgeon declare: "It is all metastatic. See here?" The surgeon pointed at a white lesion inside Aaron. I could feel my heart race. "Let's send this to pathology, write down metastasis with a question mark on it", the surgeon instructed the nurse as he placed one of the lesions inside a sterile cup. I felt my breath becoming uncomfortable. The surgery continued but I was feeling faint, trying to hold it together. The phone rang: "they say it is", the other nurse reported. Air was coming in and out of my mouth but I felt as though the air ran out of oxygen; I was having an anxiety attack inside a sterile zone of an OR. Slowly I calmed myself down, telling myself I do have enough air, that I can breathe and that it will soon pass. After a few long minutes I was back, I helped take Aaron's stomach out and to re-connect his esophagus to the rest of his bowel. The surgery was over. We didn't leave any part of his stomach inside.

During the next few weeks I made sure to stop by his room every day. "How are you feeling?", I asked. He looked weak and pale. He and his wife were always thankful when my fellow students and I came to check in on them, and they smiled at us and their eyes lit up. During my daily visits I got to know them a bit better; where they lived, their professions and they also told me that they do not have any children. A few days after the surgery, Aaron seemed to have been getting stronger. But then, one morning, when we walked into their room, they told me about the night they'd had. There was a leak from one of Aaron's blood vessels and he was rushed to the OR. The next morning, he looked pale and broken. On that day Aaron's wife asked me about the first surgery, about the metastasis. She wanted to know if they took them all out. She didn't ask whether he was 'going to make it' and recover, but I assumed that it was on her mind as well. I didn't say much. I told her that every metastasis they found was removed,

but I never asked her what she understood or if she was afraid. I left no room for a conversation in which she could express her fears.

When the clerkship was over I was able to take a deep breath and start processing everything that had happened. During the clerkship I felt that many times things were not done the way I was taught and expected; especially interactions with patients and the attitude towards pain. When I saw the patients' pain I could actually feel it too. I smiled at patients and softly touched their shoulder trying to comfort them and to take an active approach that would decrease my distress. I felt like a shield between the patients and the doctors, but I wasn't relieved, rather I was angry and upset instead. I felt that the surgeons were professional and decisive but I expected the interaction with the patients to be somewhat different than it was. I suppose I had expected that in a place such as a surgery ward, where there is often greater suffering and ambiguity, the medical staff would be even more attentive compared to other wards and would allow more space in which the patients could express their emotional needs alongside their medical ones. Since that was what I was taught and also because that is part of my character, I was oriented towards interaction with patients. I naturally took upon myself a position of a mediator between the medical staff and the patients and although it was my choice, this position was confusing and made it difficult for me to form my professional identity.

The surgery clerkship was the first time I encountered pain and suffering so closely and as part of my routine. This exposure caused me great distress and made it difficult for me to view the complexity of the events. I can now see that sometimes my thoughts of emotions were drawn to the edge. I sometimes viewed the events as though there were two sides; the one of the patients and the one of the doctors. I understand now that while I was focused on the interactions and the patients' emotional needs, the doctors in the ward had other concerns that were hard for me to fully understand at that time. They had to worry about complications that may arise after surgery, and their other professional obligations such as the burden of the crowded ward. They had to identify situations that required their immediate, urgent attention and to promote them to the top of their priorities. I was in a position where I didn't have much knowledge about the medical part of the rounds and could more easily relate to the patients' experience rather than to the experience of the doctors. On the other hand, I wore a white gown and walked the rounds with the other doctors so I was in fact one of them in the eyes of the patients. I wasn't sure whether I actually wanted the patients to view me as a medical authority at that point in my studies as I perceived myself closer to being a patient than a doctor.

These feelings continued as I was asked to do things that didn't seem right to me, as happened at the pre-op meeting I've mentioned. The teenage boy who came in seemed so embarrassed; I could almost feel it too. When I was asked to examine him the first thought that came to mind was: why me?! I had never examined someone's testis before, and even if I had, I wouldn't have wanted to do so again in a room full of people and to embarrass a teenage boy. But I felt that I had no other choice. I felt that I was being pressured and couldn't see the surgeon's point of view. He wanted to teach me something and as he wanted to take the opportunity to provide me with a new and important skill, I could only see the discomfort of the boy and it made me angry that the surgeon hadn't noticed it too. I am usually fairly calm and relaxed but I think my anger caused my body-language and voice to become aggressive. As I was feeling pressured, I pressured the boy in turn and didn't allow him to say no when I approached him, thereby I felt that I was punishing him and taking my anger out on him. The disappointment that I projected towards my supervisors, the doctors, at first, was later reflected towards myself for cooperating with what I viewed as a foul behavior.

Meeting Aaron and his wife was a distinctive encounter for me, the emotional connection that I felt towards him was different compared to any other patients that I have met so far. When I saw them walking in for the first time at the pre-op meeting, I thought: how beautiful they looked together and how young and handsome Aaron was. There was something about them, their story or perhaps the way they looked together. Maybe they had even reminded me of my partner and myself, I am not sure, but they captured me. It was apparent that his wife was nervous at the meeting by the way her hand embraced her purse as she sat down next to him. I thought I recognized a certain distress in her that was familiar to me from the times my husband was called away to army reserve duty, and only then I noticed that Aaron was nervous as well. This process of identification enabled me, for a split second, to unite with them and to try and better understand what they were going through.

Their pre-op meeting didn't go the way I had expected, especially the way it ended and the tension around the obvious topics that weren't discussed at that meeting. As part of our pre-clinical training we were taught how to end a meeting properly during a course on communication. It was suggested to tell a patient that the meeting is coming to an end and to check if there is anything else that he might want to ask. We sat there, 9 students, some of us top students, and none of us said anything. I was also taught by my grandfather about 'the doorknob syndrome' long before I even started medical school. His stories about the medical world, about how every person that comes into the room is a whole world, his descriptions

about the sensitivity needed to decipher what is really bothering someone and how satisfying it could be to succeed were a big part of my decision to become a doctor. At the pre-op meeting, I could recognize Aaron's hand hesitate around the doorknob when he and his wife got up to leave, but I didn't stop them. I wasn't a doctor and it wasn't my place, I thought.

As happened with other patients, I wanted to protect Aaron. Trying to protect him while feeling as ashamed and worthless as I was feeling during the clerkship, was not an easy undertaking for me. Everything that I had done didn't seem worthy through my eyes; at his surgery I nearly collapsed - I couldn't save him from his disease and couldn't keep the promise to leave a small part of his stomach inside him. At the ward I felt helpless as I imagined Aaron and his wife sitting all day waiting for someone to come in with answers or news and all they got instead was me. Even when I was given the opportunity to assist, the day Aaron's wife wanted to talk about Aaron, I was controlled by my fears and frustration.

I didn't feel qualified for the doctor's job yet. I wished that the doctors would have sat with Aaron and his wife beforehand and talked to them about everything; what would happen during the surgery, the prognosis for Aaron's disease and what they should expect on the road ahead. I wished the doctors would have answered their questions so there would not be any left to direct at me, but Aaron's wife approached me before any of that had happened and I felt angry at the surgeons again for that. I thought that I couldn't answer her questions because I didn't have sufficient knowledge, because I was not an expert in surgery or oncology and because I feared I didn't have the right tools to go through this conversation without causing harm. I didn't feel a part of a team or that I had someone I could learn from as to how to manage these kinds of conversation. I felt alone and abandoned. For all these reasons the conversation between Aaron's wife and myself didn't go as well as I hope it would. Most of all I regret for forgetting my grandfather's most important message – listen to the patient, perhaps that was all Aaron's wife needed at that time.

My experiences in the surgery clerkship required great mental effort from myself. I remember at times, while I was driving my motorbike to the hospital in the morning, wondering if it wouldn't be better if I fell, if something bad would happen to me, so I wouldn't have to go there. It was a time in which there was tension in my relationship with my partner and a time of anxiety and bad moods. A year later, studying for my psychiatry exam I could look back and diagnose myself with some form of adjustment disorder. It is hard to look back at a time that I remember as being so awful and try to see it as an empowering period. I still wish I hadn't had

to go through it but, as happened to me at challenging times in the past, a difficult time was a chance to grow. I learned that the personal interactions matter to me the same if not more than the medically relevant issues. One of my insights about that time was that my weakness of identification with the patient's experience that made my experiences as intense as they were, was probably one of my strongest characteristics as a 'nearly physician'. I came to realize the fact that the reason the indifferent behavior bothered me so much was only because of my own commitment to my patients which was in fact a good thing. Also and perhaps most important, there were times I found myself acting aggressively and insensitively to patients just as the surgeons that I disliked did. I was aggressive towards the boy, towards the doctors and also insensitive to Aaron's wife needs. As much as I would want to deny these parts of myself, I embrace them because I understand that I can reflect and criticize these moments. The ability to think about my emotions, beliefs and thoughts as I am speaking to a patient is an ability that requires much practice, but I am willing to utilize daily encounters that occur many times in the medical profession, to improve these skills and hopefully that will be my virtue.

Having learned these lessons, my ears were open to hear any advice that would help me in a similar situation in the future. I found other role models; doctors, who treated their patients and acted in a way that I would want to see myself act. With my additional role models and with ample advice I got from the social worker of the oncology department about how to speak to a patient about sensitive subjects in the future, I was starting to feel that I was forming my professional identity. I was starting to feel ready to face my fears.

While writing this, I am about to finish my final year of medical school. I chose my school based on its almost revolutionary approach for medical teaching and training. I learned so much during my training about communication skills and a patient- centered approach and I am grateful for that. I feel that as the number of students rise and the medical knowledge expands, the medical school is faced with a vast challenge to try and preserve their special features and student-centered tutoring.

Throughout the clinical training at medical school, I felt that many times I was being evaluated based on my medical skills alone. After a ward round with a group of students I remember receiving feedback about the way one palpated or the quality of one's percussions. I can't recall receiving such feedback on the connection that was formed with the patient or the quality of the interaction with the patient. I also felt appreciated when my medical admissions had a good discussion or DD, but not when I had done a good job on the personal level. What I think was

lacking during my training is feedback about my personal strengths and areas that I might want to work on and improve, feedback that would help me evolve as an individual as well as a doctor. An exception would be the family practice training, which was one of the most empowering periods of my training; it was a time where I felt that I was being seen.

In addition to Balint groups that enabled me to reflect and developed my tools for self-reflection, I believe that it is also important to teach students how to channel their self-criticism into productive actions. I believe it can be achieved by encouraging each student to develop his interpersonal skills and to evaluate each student based on his progress frequently. I think it should be done as an integral part of medical studies on wards and not only at an extra-curricular mentoring program that is now growing and much appreciated. That would not only develop the feeling of self-capability and resilience of students by the mirroring of their progress, but also remind students that besides the books and guidelines that each one has to learn and master, medical school is also a time to invest in personal development, an area that is not inferior in magnitude.

Epilogue

At the end of that same year of my surgery clerkship I was working evening shifts in an internal medicine ward, helping the intern with admissions. I took a case of a 58-year-old woman who transferred to our ward from the ICU. She was after surgery where part of her lung was taken out because of an SOL. After the surgery, she deteriorated; she was intubated and had some heart damage as well. I don't recall her entire medical background, but I do remember reading her file, seeing the pathology report diagnosing her with lung cancer that had been received a couple of days earlier. I was trying to understand if at any time during these days anyone had told her. It wasn't written anywhere, so no one had. I told the intern what I had found, and he told me that I don't have to tell her, he said I just had to finish the admission and that he or someone else would talk to her about it later or perhaps tomorrow. It didn't feel right to me, as I remembered Aaron and his wife and how much I felt that they had wanted to get some information. By that time, I was feeling more confident with my place as a part of a medical team, and in my abilities as well. I figured, perhaps I had less knowledge than the intern but I did have more time than he did at the moment; there was a chance that I could be more attentive than he could be with the whole ward under his responsibility, so I went up to see her.

I sat with her. We talked a bit about how she feels. She told me about the last months' events, about her life and her family. I have noticed that it is not too difficult for me to make a connection, it became easier once I had realized my grandfather was right - all I had to do was listen. After a short while, I felt that we had created a relationship that enabled me to share the results with her. I told her that the results from her surgery had come in and asked her if she would like to hear about them. She immediately said yes. I asked her when would she like to hear about them, she quickly replied: "right now", and my final question: "do you want anyone to be with you for this conversation?" She told me that she was strong, that she was not afraid to hear and that she didn't want anyone else with her for that moment. I sat with her and patiently explained to her what was written in the pathology report. I apologized for not knowing much more, and promised to send an oncologist to speak to her the next day. For me, the significant part of the conversation was that I was able to listen to her worries and concerns despite the discomfort they may have caused me. I could listen to her questions even when I couldn't answer them without feeling any less of myself. I was feeling confident about my position as a student, part of the medical team but also close to the experience of the patient. I was feeling grateful for being able to enjoy this special position for a little while longer.

GEORGE

Michael Watson

Tuesday

I opened the door of the cramped interview room at the behavioral health unit and allowed him to leave ahead of me. As I step into the hallway, I feel, suddenly, awake. Reality is here.

I spent two years before today learning about physical and mental pathology in classrooms, books, question banks, standardized patients and artificial encounters. It dawns on me that until now, pathology existed only in those realms—only in theory.

George is 38, a husband and the father of a 12 year-old girl. My preceptors chuckled while reviewing his chart when they saw he's receiving disability payments for Temporomandibular joint dysfunction (TMJ).

He landed on the inpatient behavioral health unit because on Friday, he told his wife—in a calm, collected fashion—that while he's not sure, when or how, but soon—he's going to kill himself, and she should prepare for that.

The following Monday, a police officer showed up at their house and took George to the emergency department of the hospital where I just stared my clinical education.

Today is Tuesday. George is wearing red and black, plaid pajama pants and a yellowing white T-shirt. He has a round, boyish face, brown hair, and a patchy, ungroomed beard. He is overweight, his skin and hair are oily, like he hasn't showered for days. He looks like he could work at a video rental store, in the video game section, if those were still around.

"Hi George," I said. We walk from his sparse, two-patient room, down the dimly lit hallway to the oddly named interview room.

I wonder how patients feel about the interview room. *We might as well call it the interrogation room*, I think to myself. It's small; there's a desk with a computer on it, an obsolete metal filing cabinet and a circular table crammed in. It gives the room a storage closet feel. We sit down across the table from each other.

"I'm Michael, I'm a medical student. It's my job to collect a history from you so I can then present to the team and help them shape your care."

"Ok." He replied briefly but pleasantly.

"So tell me, what's been going on?"

George is in a talking mood, beyond the formalities. I discontinue my generic questions and listen.

He speaks in a low, even tone—matter-of-factly—and at a steady pace.

He doesn't do any thinking during our meeting. He's probably already thought about these topics to exhaustion; it seems he's been awaiting a prompt from a mental health professional to tell his story. *I guess that's me.* I attempt to fill the role as I listen.

Part of me feels I am deceiving George. My white coat and ID badge feel like a disguise, concealing my laughable seven days of experience. I ponder the legality of the situation before returning to the present.

He starts by explaining the immediate circumstances surrounding his admission, easing in and testing the waters for sincere interest.

George is smart. He understands people, expresses empathy, and has insight into his emotions. Most strikingly, George is rational.

He explains, clearly and objectively, the circumstances that led to suicide being a reasonable course of action.

We progress from acute factors to the chronic factors that laid the foundation. His chronic pain keeps making its way into our conversation and it's clear he is hesitant to expand on the full extent of this handicap. I'm certain he's aware of the judgment passed by ill-informed health care practitioners on his disability status for TMJ.

A wave of guilt passes through me as I recall my participation in the chuckling this morning. On top of his suffering, those who are supposed to be caring for him question his character and the validity of his condition. For a short moment, I feel his isolation. It is a feeling of hopelessness.

I attempt to validate his challenging circumstances and we advance a step deeper.

By the end of our meeting an hour has gone by. He thanks me. It is sincere.

"You are the first person to listen like that. I feel a bit better. Sorry for the length."

Little does he know, listening is about the only tool in my arsenal. Anything I say will probably only serve to reveal my inadequacy.

We leave; I walk George to his room. Crashing down in the medical student room, I feel a breathtaking wave of experience. *What the hell just happened?*

The patient's trust and the depth of the interaction yanked me from my typical self-conscious, medical student headspace. I feel refreshed.

This is paired with anxiety pertaining to the task at hand. The complexity and extent of George's present illness is overwhelming. It's impossible for me to hold everything in my head at once. And I have 30 minutes to digest, organize and present George to an audience that appears to be the last people standing between him and suicide.

I start scribbling down everything I can remember. I remember way more than I have time to write. I take a step back. *You know this. You couldn't forget that story if you tried.*

I shake the assignment mindset and forget the template I have in the back of my head. *Breath in. One-two-three. Breath out.* I attempt to rest my jittery neurons. *Less think, more do. It's all there.* I think of how often I get in the way of myself. *Relax and flow, relax and flow, this is too real not to.* I jot down a few bullets to keep me on track and fill in medical history, medications, etc.

30 minutes later I'm sitting at a large oval table in a conference room adjoining the psychiatrist—my attending's—office.

It's 11 o'clock.

My knee is bouncing up and down energetically. My heart intermittently picks up rate, then slows. I attempt to listen to the physician assistants and other medical student give updates on our patients as they work down the list, but my mind is consumed by the opening lines of my presentation. I repeat them over and over again, *"38 year old male, history of…."* I glance nervously at the rest of my notes, hoping everything comes out of my mouth in a logical fashion once I begin.

"George T! Our TMJ suicidal ideation guy. Who saw George?" my attending speaks up.

"I saw George." I reply, trying to conceal my anxiety. "George is a 38 year old male with history of major depressive disorder and TMJ who was brought to the ED and voluntarily admitted Monday for suicidal ideations without a plan. Monday of last week his wife of 15 years told him she was planning a divorce. After four days of very low mood and isolation in the basement apartment of their house, the patient decided he would kill himself and began ruling out ways he would do it. He notified his wife of these intentions Friday. She notified his therapist later that day. The decision gave the patient relief and he spent the weekend upstairs

with his wife and 13 year-old daughter.

"The patient hesitantly expressed that chronic TMJ, which began five years ago following a dental procedure, limits his ability to work, speak, exercise, socialize, and stay positive. When he tries to be more active he has a 24-hour period of increased severity of symptoms. His inability to do these things has damaged his relationships, including his marriage. He has seen many specialists and received three years of talk therapy for his pain with little relief. He does not believe he will find relief from this pain.

"He also revealed that he was adopted. His first attempt to meet with his biological mother was at 18, at that time she only seemed interested in him for financial support. At 35, he made a second attempt to befriend her and during these encounters he began asking about his father. She revealed to him that she did not know who his father was because she became pregnant with him after being raped by three men at the same time."

I pause, my chest is full of air, heart racing. I exhale…breathe in and begin again.

"He stated that he feels, in some way a part of this crime. Protective factors include his daughter. He states that if he were to not do it, it would be for her. But in exchange, he'd be consigning himself to a life of suffering.

"He has friends but does not feel he should burden them with his problems. When I asked what they would say about that assumption, he acknowledged that they'd like to help.

"He endorses difficulty sleeping, anhedonia, feelings of guilt related to his disability, decreased energy, difficulty concentrating and suicidal ideations. Denies changes in appetite and denies homicidal ideations. He has no history of suicide attempts."

During the assessment and plan I drop the formality and express my concern. "This seems different. He seems very rational."

"Those are the scary ones," my attending replies. "If we let him out of here today, do you think he would do it?"

"Yes. I'm not sure when, but yes, I think he would."

And I do. Part of me thinks *I* would do it if I were in his shoes.

That night I keep thinking about George's situation. "*Where's the pathology? It's not completely unreasonable.* I've heard suicide referred to as "a permanent solution to a temporary

problem". *Perhaps in this case it's a permanent solution to a permanent problem.*

I imagine what it would feel like to be beat down by "8/10" pain every time I got motivated to be a better husband, be a better father, be active. What it would feel like to be in pain for five years with a condition some people don't believe exists and to feel you've exhausted empathy from everyone and you are now just a burden? I shutter at his words, "my wife told me she has to move on".

It's hard to even contemplate the second kicker to his situation. *Raped by three men at the same time!* I feel uncomfortable just thinking about it. *I felt uncomfortable presenting that. He must feel gross. I might kill myself.*

I don't have the courage to ponder further and I attempt to think about something else.

Monday

It's Monday night, six days after my first meeting with George. I spent Wednesday and Thursday of last week at the behavioral health center and met with George both days. On Friday I got an email from my attending, "We discharged George today. He wanted to thank you for all your help. Passing the message. Good work."

The email and George's effort to thank me was touching. I feel like I made a connection with him. Most of what I did was listen and he thanked me for that at the end of each meeting. Word of the discharge however, left a strange feeling in my stomach.

I continue to contemplate; *he did want to leave.*

On Wednesday he expressed to me that he felt trapped, "I'm slowly realizing that I can't exactly leave."

I awkwardly attempted to tip toe around the situation with the standard excuse, "Well, you can leave if you really want to, but the team would like some more time to watch and help you out."

By Thursday, he was openly frustrated, but did not threaten to sign out AMA.

He did seem to be reenergized. And while he began reporting he was no longer suicidal, there was also his intelligence and clarity to consider. A part of me certainly believed he had misled us about his improvement in order to—for lack of a better word—escape. *Hmm.*

My roommate (and classmate) is just getting home. She is acting odd. She was at the behavioral health center last week and is there again this week, but I'm not. She sits down at the kitchen table across from me.

I just finished eating but I'm happy to have her company, so I stay. I smile at her, "What's up with you, weirdo?"

She looks up at me, smiles for an instant, then her face drops; she's sad and serious.

"I have to tell you something. I'm not sure I should, but I can't not."

My heart pounds.

"George killed himself."

Weakness all over, my stomach floats.

"He was found in a hotel room Friday night, he suffocated himself. They think he got into a fight with his wife when he got home. I'm sorry, I know you spent a lot of time with him, the team didn't want me to tell you."

The wave of reality comes crashing in. Smash. I'm dazed for a moment. Then the thoughts. *I really screwed up. How did he suffocate himself? They weren't going to tell me? Maybe a plastic bag. He's dead. O no…his daughter.*

Then the images: him on the floor, a cheap hotel room, tan carpet, head inside a bag, his daughter.

I step outside to absorb, to sit with it. It's a cool clear night and there's breeze. I try not to actively think. I sit on a steal patio chair and try to observe the thoughts that arise and what this feels like in my body. Waves of randomness, questions, and twangs of pain at the thought of his daughter, roll in. Then a calm settles over.

I hear the hum of a distant highway. He's no longer a part of this; this hum, this movement, these ups and downs. He is still now.

For him, the game is over. He quit on his own terms.

I sit outside in the crisp summer night, for how long, I'm not sure.

Looking Back

I do not carry regret regarding this case. I am thankful for having been able to care for George during his last week and in a manner that pleased him. He was competent and had denied suicidal and homicidal ideations before discharge. We let him have the call at the expense of our own unease.

The alternate would not have sat right with me either; holding him there against his will, like a mother attempting to protect her child from the world by keeping her in the house.

The issue of defining quality of care comes to mind—the outcomes versus patient satisfaction dilemma. George was satisfied with his care, or at least more satisfied then he would have been if we held him there for another week. Although the outcome, most would say, was poor. Where do our responsibilities lie? With the patient or with the patient's health?

As challenging as the outcome of this case was to swallow, if a patient has capacity and no one else is in danger, I resolve to stick with the patient. It must be less about what we want for the patient, and more about what the patient wants for him or herself.

With that resolve, the next step, for me, is determining what it is that the patient needs and wants at any particular moment. To do this we must listen. My experience with George engrained in me the importance of listening with no agenda. He taught me that listening is often the best therapy *and* sometimes the only therapy. I will strive to listen in every encounter.

I also learned that at the end of listening, problem solving is not always warranted. Just acknowledge, just absorb.

We reflexively *do* all the time. There is a disconnect here and it creates a problem. Many healthcare practitioners say they support shared decision making but when that means doing nothing from a pharmaceutical or procedural standpoint, there's a moment of confusion in our problem solving brains, an error message if you will. At this point we push forward and often default to programmed routes of action. This leads to things patients don't want and the payers definitely don't want.

Perhaps we do this because we can't handle the awkward silence. We don't know what to do with it so we fill it with big fancy solutions.

Medical training can be enhanced by encouraging non-pharmaceutical, non-procedural, therapies; simply being with the patient, being present, reassuring the patient and validating their struggles. Listening. These are solutions, these are therapies, and they leave both patient

and caregiver feeling better. George taught me this.

Additionally, we must remember that people die and that that is okay. Most of the western world has death phobia. We're afraid to think about it, we're afraid to talk about it, and we're afraid to prepare for it. Western medicine promotes and exacerbates this phobia. Death and disease is painted as a villain, bound and determined to take the patient away to somewhere that must be pretty awful because we are the heroes and we will not stop fighting this until every weapon in our arsenal has been exhausted.

This case spurred me to do some internal work on death. I have long been curious about death and have read Elizabeth Kubler-Ross' *On Death and Dying*, as well as Atul Gawande's *On Being Mortal*. If these texts were required reading in every medical school that would be a great start to changing the culture and language surrounding death.

The next step might be the internal work that George's case instigated me to perform: contemplations on my own death. Not the quick thoughts that we shove aside but deep, dedicated meditations on my own mortality, on what it might feel like to die, on the contrast between fighting death and accepting it.

I imagine it as similar to being cold, I imagine myself shivering, drawing-in, chattering—fighting, resisting. I imagine that to accept I open-up, breath deeply, calm my body, and that at that point I pass through a quick wave of heart chilling cold before I no longer feel cold and a blanket of tingling warmth settles over me and puts me to sleep.

These types of meditations have been hugely beneficial to me. They've helped me to see death as a much-needed stillness at the end of the relentless movement, up-and-down, and reaching that is life. They have reduced my own fear of death and as a byproduct I believe they have enhanced my ability to provide appropriate end-of-life care. Something we desperately need.

On a personal note, I often think about George. He will appear in my thoughts at times when I am really happy—staring up at a brilliant night sky, bathing in warm sun on a cool day, waking up on a Saturday morning with tons of energy—moments when I'm in awe of the world and excited about life. I am instantly thankful, thankful that my life circumstances have played out pretty well thus far. I'm renewed to enjoy my life to its fullest.

I feel sorry for George and the cards he was dealt, but relieved that he's not suffering anymore. I get a feeling that he is free from the dark, dire world he became trapped in.

There are many who find themselves in cracks; in places that aren't fair, in situations they did not create and cannot escape. Before entering the healthcare field I didn't fully grasp this concept. I was sheltered. As a part of the field, I now see this all the time. I realize it's a secret burden we all carry and that those before us carried. I'm proud to be a part of this profession and I'm proud to have been a part of George's care. He taught me that as a future physician I may be able to cure some people but as person I can *care* for all of them.

PAPERS RECEIVED BUT NOT DELIVERED AT CONGRESS

BALINT GROUP AND SUPERVISION: SIMILAR OR DIFFERENT?

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ABSTRACT

The development of Balint groups in the 1960s started with general practioners (GPs) and social workers.The Balint group is nowadays widely spread and accepted. Consequently, in many countries integration takes place into medical, psychosomatic, psychological and psychotherapeutic further education. This background leads to a blurring and occasionally to an equalisation of Balint groups and supervision. In this paper, differences and similarities between Balint groups and supervision are explained with regard to theory, technology and content. This has only rarely taken place in the past.

The aim is the understanding and elaboration of similarities and differences between Balint groups and supervision. This is of great importance for the development of the practice of Balint groups in general and clinical medicine and thus of its origin ("five minutes per patient"). The practice of psychotherapeutic supervision will benefit as well.

Balint in medicine

The first group of general practitioners of the kind typical of later Balint groups emerged in 1950 as "A Discussion Group Seminar on Psychological Problems in General Practice". (Balint, 1954).

The Balint group has now has become an integral part of continuing education for specialists in psychiatry, psychosomatic medicine and psychotherapy, pain medicine and other somatic subjects. Thus, there are increasing cases of short - term or middle - term psychotherapies presented in Balint groups. Even psychologists present cases from ongoing treatments.

In principle, this should be welcomed. Many psychotherapies can be better illuminated and reflected in a larger group in this way. This corresponds to the need of many doctors and psychologists. In other helping professions, too, the Balint group has become an important component of self-understanding. It was to be expected that the distinction from psychotherapeutic supervision in the narrow sense would often be blurred.

What is a Balint group?

In the classical sense, a Balint group is a working group of about six to 12 doctors, who meet regularly under the leadership of an experienced psychotherapist to talk about "problem patients" from their practice. The aim is an improved doctor-patient relationship, which finally leads to a deeper understanding and a more appropriate treatment of the patient.

What is supervision?

Supervision is a form of counselling for practitioners in the psychosocial professions. Supervisions, in general, are carried out by a qualified practitioner experienced in the appropriate field. We are talking exclusively about psychotherapeutic supervision.

In psychotherapeutic supervision, the focus is mainly on method competency, biography and diagnosis of patients (case-by-case) and, in individual cases, on collaboration with the institution. Also, the cooperation within the team or the organisation, role expectations and role behaviour and the relationship between case-presenter and patient play a role.

Both group forms have in common the possibility and the willingness to allow self-observation aspects to arise.

In the Balint group the practitioner's personal experiences should only be implied; we occasionally refer to "work-related" self-experience. This means a focal, limited experience with relevant significance for a meaningful repetition of a similar situation - in the best case referred to as "Flash".

In supervision, these impressions are inserted into the participant's own personal self-analysis.

Different case presentations

In the practice of Balint group work, there are nowadays two different developments of case presentations:

-a. The case presentation which has evolved from a longer psychotherapeutic process.

-b. The case presentation of the general practitioner, the specialist from practice and clinic. These are of encounters that touched the speakers. They are affectively impressive and lasting memories with immediately perceptible or not yet accessible and understandable feelings and resulting communication disturbances. They are essentially based on the principle of transference and countertransference. This originates directly from practice.

Both types of case presentation are possible, meaningful and appropriate. It is, however, necessary to reflect on the initial situation and to observe the composition of the group.

Of course, the participants should come from different professional groups. The interdisciplinary aspect, the exchange between different professional groups, is especially important, having its own value and is a process which promotes communication and understanding. The encounters in Balint groups are free from the categories of diagnoses and the often associated implicit truth.

For further differentiation and understanding, in the subsequent sections a distinction is made between structure and content.

Structure:

The Balint group is a group of six to 12 participants in its original structure. Supervision, on the other hand, can be either single or group supervision. In supervision of psychotherapy in a group, usually only four participants and one supervision leader are present. Additionally, the dyadic events are not exclusively in the foreground. No confusion with a Balint group can occur in supervision of a single person. However, group supervision can easily lead to confusion with a Balint group.

The aim of psychotherapeutic supervision is not only a different understanding and access to a relationship between two persons, but also the experience of a multi-dimensional interaction field and the consequences of institutional framework conditions.

In supervision, the same case is regularly discussed- especially in the training situation, for example after every fourth hour of therapy. In Balint group work, the case is usually presented only once. This single presentation happens with the ideal aim of an in-depth understanding on the basis of transference and counter-transference.

In supervision of the psychotherapeutic process, so-called technical rules can and should be observed. How is the mindfulness toward resistance and dealing with it? How adequate is the interpretation process, etc., how is the classification in the understanding of theoretical, psychoanalytic - psychodynamic models?

In psychotherapeutic supervision the biography, the developmental history, the psychopathology or other symptoms will be more prominent. These are requirements of the framework conditions of funding and application and of the self-defined or imminent further objectives of the treatment. This is also important in Balint work, but can only be considered as material in the context of free association and imagination development. In supervision, especially in the training situation, a corresponding preparation - be it mental or formal - has already taken place e.g. by a transference, which is then presented. This leads to the fact that not only condensed, strongly affectively shaped encounters are subject in the narrower therapeutic relationship - in contrast to Balint groups. There will also be biographical questions, psychopathological and social problems relevant with regard to the therapeutic process. In supervision, the training or control case, the ongoing case and the difficult case are presented. Even with a one-time presentation, the presentation is more aimed and based on a previously made decision.

Content:

Type of case presentation:

There is no need for preparation for a case study in a Balint group.

At first, the question of input is made in various modifications: "Who would like to present a case today, a case of a doctor - patient encounter that touched me"? One is supposed to talk

about what is important at this moment and what appears to be of lasting noticeable importance. After the brief presentation of the encounter, and possibly additional questions seeking further factual information the group members are encouraged to let this presentation rise in their inner pictures, feelings and fantasies - the basic rule of free association. A certain kind of immediacy and spontaneity of the presentation is of importance. This will be decided in this situation - it does not exclude that it was consciously prepared or "pioneered". This refers to the original situation in which the doctor comes from the practice "five minutes per patient" (Balint, 1957; Balint, 1974; Balint and Norell, 1977) and the "most urgent" is emphasised.

Scenic understanding

In addition to scenic understanding in general as an element of a deep-psychological and analytical basic understanding, in terms of Argelander (2014), the entrance scene is essential. This is the very first encounter, verbal and non-verbal, but perhaps also the "first" encounter in the respective therapeutic hour. In Balint work, there is a unique first scene in the specific encounter of doctor and patient.

The "entrance scene" in Balint groups has a different meaning than in a supervision group. The "Balint case" should not lie too far behind and / or should be characterised by an affective occupation of the encounter with a patient. The "case" is supposed to be created in front of the inner eye of the speaker right at the beginning of the group. It consequently becomes significant in the group work by the process of free association. The inner process could already have developed in the hours before the Balint group. The significance of the encounter should be perceptible and lead to the presentation of the case.

Free association

In terms of the structuring elements, the demand for free association is the main emphasis in Balint group work, and partly also dependent on the group's self-understanding.
Of course, free association also is possible and desired in control supervision, but the reflection of the determinants needed for the psychotherapeutic process hovers in the background. This is done certainly depending on the personality of the supervision leader. The aim is to understand the psychotherapeutic process as a whole, in diagnostics (in depth

psychological-analytical understanding) as well for therapy (interpretation, defences, affects, abstinence, consideration of the legal framework conditions, etc.).

Self-knowledge

On an open scale with registration of cognitive and / or emotional self-knowledge, the self-knowledge in the area of supervision would be assigned stronger cognitive parts; in Balint work rather stronger emotional parts. This distinction corresponds to the different objectives of Balint and supervision. In Balint work, the possibilities and chances of group dynamics guarantee a reinforcement of the emotional and affective parts of the experience. This requires the acceptance by the group participants of the basic concept and ideas of the Balint group and their framework, with a limited, possibly focused, so called "work-related" self-experience.

Psychodynamic group process

The size of the Balint group naturally determines the possibility of a psychodynamic group process. This will undoubtedly also be perceived in a group of supervisees, but this is not the focus of attention. However, the development of Balint group work has shown that group dynamics are an essential element for the development of a focused view on the relationship between physician and patient. With regard to the transference and countertransference processes and the recognition of the blind spots – so called scotomas- this is fruitful and necessary.

Within the group and its group dynamics we refer to reflections and parallel processes that happen in the reflection on the doctor - patient relationship. The revival of emotional situations and the repetition of transference-figures within the group are named. The Balint group leader can take this up, comment on the event and thereby promote development.

In Balint group work the perception of solidarity and of the varying identification on trial is significant both with regard to the speaker and to the desired reciprocal identification with the persons involved in the presented case.

Focusing on the doctor-patient relationship

In classical Balint work, the focus is always on the doctor-patient relationship, meaning in the dyad. Of course, the intervening variables are also taken into account in the development of the "three-person piece" in the sense of triangulation and the "multi-person piece" in the sense of the family and social environment. With regard to psychotherapeutic cases presented in a Balint group, this focus on the two- person event can be productively exploited. Especially in the case of non-psychotherapeutically trained physicians and psychologists, it has proven to be advantageous to refer to patterns in Balint group work - patterns of the two-person, the three-person and the multiple-person relationship, patterns of conflicts and clashes. This is advantageous as a simplified formulation for possibly more complex relationship conditions.

Leadership

Differentiations between Balint groups and supervision also have consequences with regard to group-leadership and the handling of interventions. In a Balint group, these should be "sown" rather "scattered", with the leader acting as moderator or in the image of the coachman, following König (2004): the reflection of the leadership under firm or loosened bridle with all consequences for the group development.

An essential variant of Balint group work originates, inter alia, from German-speaking countries. It invites the speaker to withdraw after the presentation of the case, after the doctor-patient relationship has been presented and after supplementary factual questions of the group have been answered. This is sometimes referred to as the "pushback" and implies a call for the group take back the discussion mentally within itself. The aim is for the presenter to hear, to feel, to assimilate and to take in the free associations of the group participants and the resulting moods, developments and statements of the group equipped with all feeling qualities. The introduction of this "rule", this possibility and a support of this genuinely group-oriented process is - in contrast to a Balint group – not part of the process of a psychotherapeutic supervision group.

Intervention

The subject of supervision is not least the "intervention" in a broader sense.

In the classical Balint group, this is not aimed for and it is rather reservedly treated. The classical Balint work assumes, however, that the emotional and affective processes taking place in the presenter have their own effectiveness. The spontaneous efficacy of this group experience, especially in non-psychotherapists, is pointed out again and again.

Nuclear elements are the reference to mirror phenomena in the depicted relationship and the interaction field of the Balint group. This leads to a more immediate experience particularly of the emotional character of the doctor - patient relationship. Meanings, affects, significances are named and in so far as this is not sufficiently accomplished by the group itself, interactions are designated. By this realisation and this experience, a "reversal of attitude" as formulated by Trenkel (1987) happens. The attitude within the encounter towards the patient has changed in the subsequent period, in part only slightly, but decisively.

The leader decides - in the best case - for a free or a tighter leadership, depending on the developmental stage of the group and on the emerging topic. In any case, everything is done to support mentalisation and internalisation processes.

Consequences

The explanations show that the leader has a decisive function both in terms of the differences in technology and the framework conditions as well as in the focus on content. In his self-understanding, he has to continually reflect and keep this apart. In supervision, he has to take into account the indications, which are performed under psychotherapeutic aspects, the optimised treatment processes, and the psychotherapeutic techniques performed "lege artis". The integration of self-experience and the way of working with patients in general medicine or in psychotherapeutic practice must be taken into account from a professional point of view.

The Balint group leader has to open, to name, to accompany the affective rather than cognitive experience area that emerges from the framework of the Balint group. He also has to pay attention to the dynamic developmental capacity of the group. The experiences and knowledge processes of the presenter should be carried out with a maximum opened

developmental freedom. They can and will ultimately lead to a change potential, which was intended by Michael Balint. This - at the best - has in turn a self-liberating, self-evident character.

This is certainly also true for supervision and the psychotherapeutic process. However, a corresponding higher professionalism with regard to the targeted training situation and the even stronger requirements of autonomy in the psychotherapeutic practice is required.

The above-mentioned distinctive features are summarised in Table 1:

Table 1: Differentiation between Balint groups and supervision

Balint groups	Supervision
Group 6-12 people	Single -Supervision max. 4 people
Unique presentation	Regular presentation
Free association is essential	Free association possible
No technology	"Technique" of psychotherapy
No preparation	Preparation essential
Self-knowledge cognitive < emotional	Self-knowledge cognitive > emotional
The first scene of the selected presentation	Entrance scene at the beginning and at each therapy session
Group dynamics	Group dynamics rather small
Joint, solidarity and rehearsal of the group with speaker and rooted relationships	For the group rather less significant
Focus on the current questions and work with the material that comes from the group	Biography, psychopathology, diagnostics, psychotherapeutic "technology" are to be taken into account strongly and more systematically

Similarities

The benefits and aims of the Balint group are, in the context of psychotherapy, similar in some respects to supervision:

- The first scene and the focus on it are significant.

- The recognition of the blind spot.

- The promotion of continuous self-criticism.

- The training of listening with the third ear

- The re-staging as a regular event can be experienced.

- The soundboard for the opposite is trained.

- The learning of promoting processes, not of managing, conducting and leading, is at the
    forefront.

- Closed and open systems are understood in their meaning and diversity.

- The importance of the group and its effectiveness is experienced.

- The meaning of the symptom, the symbol and the semiotics / signs are understood (under
    the most favourable conditions).

Outlook

Although certain points of contact and process similarities misleadingly point to   similarities
between Balint groups and supervision, we plead also to know the differences, to elaborate
them and to reflect and name them adequately. Special features are the size of the Balint
group, the objectives with regard to the therapy process (Supervision) and the aim of
supporting encounters in general medical practice (Balint groups) which lead to a change of
attitudes. The inclusion of psychodynamic group processes resulting from the demand for
free association, from the size of the group as well as from leadership variants are of
considerable importance.

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BALINT GROUPS FOR MEDICAL STUDENTS: AN INTERNATIONAL LITERATURE REVIEW

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ABSTRACT

Background and Aim

Doctors are required to reflect on their medical practice, and Balint groups can promote this reflection-in-action. The UK Medical School Psychotherapy Scheme Working Group aims to establish Balint groups in all 45 UK medical schools by 2017, and this review aims to identify the benefits of Balint group participation for medical students by looking at the current scientific literature. Secondary objectives were to identify challenges, and further research recommendations.

Methods

PubMed, PsycINFO, EMBASE and CINAHL were searched and relevant papers identified. References from all eligible papers were searched and a data extraction form was used to pool data from all eligible papers. Heterogeneity allowed only for qualitative synthesis and analysis.

Results

Twelve eligible articles were identified and showed that Balint groups were widely well received by medical students. Benefits include better understanding of the doctor-patient relationship, emphasis on the psychological aspects of care, increased empathy and professional growth. Some students questioned the relevance of Balint groups to their clinical practice, or struggled with the process. Limited opportunities for sustained clinical contact with patients pose another challenge.

Conclusions

Existing evidence suggests that Balint groups can be beneficial to medical students. Rigorous research is required in order to evaluate them systematically.

INTRODUCTION

It is recognised that reflection drives change in performance and is the key to an effective continuous professional development (Moon, 1999). The UK General Medical Council requires doctors to reflect regularly on their standards of medical practice (GMC, 2012) and reflection-promoting activities have also been introduced in undergraduate, postgraduate and continuing medical education.

Boud et al. define reflection as ''a generic term for those intellectual and affective activities in which individuals engage to explore their experiences in order to lead to a new understanding and appreciation''. This definition emphasises the role of emotion in reflection. According to Boud, reflection can be thought of as a four stage process which includes returning to experience (stage 1), attending to feelings relating to that experience (stage 2), re-evaluating the experience (stage 3), and then the outcome or resolution (stage 4) (Boud, Keogh, & Walker, 1985; Mann, Gordon, & MacLeod, 2009).

Balint groups are groups which utilise a particular kind of reflective practice and can promote reflection-in-action (Lichtenstein, 2006). They were initially set up in the 1950s for groups of general practitioners (GPs) and were founded and named after the Hungarian psychoanalyst Michael Balint. According to Balint, the aim of a Balint Group is "to examine the relationship between the doctor and the patient to look at the feelings generated in the doctor as possibly being part of the patient's world and then use this to help the patient" (Balint, 1964). In other words the doctor may understand the patient's experience better by reflecting on his own emotions during the doctor-patient interaction, and this may in turn help him to formulate and treat the patient more effectively. This helps us to understand why Balint groups might be useful to our everyday practice, and might aid our development as clinicians.

A traditional Balint group consists of 6 to 12 members with 1 or 2 leaders and regular meetings (weekly to monthly). Each meeting usually lasts for 1 to 2 hours, and during each group one or several members present a clinical case. Each case presentation is brief (usually 5 to 10 minutes) and is followed by a group discussion. Following their initial presentation, the presenter (sometimes called 'the doctor' in medical Balint groups) is asked to sit back and take the role of an observer, whilst the remaining group members discuss what they have heard. The focus of both the case presentation and the discussion within the group should be the presenter-patient relationship and the feelings that the patient evokes in the presenter. The role of the leader(s) is to create a safe, boundaried space in which a thoughtful discussion can take place and to keep the focus of the discussion on the presenter-patient relationship. At times the leader(s) can also introduce ideas which may help the group members to reflect on the presenter-patient relationship and stimulate further discussion.

Being a member of and participating in a Balint group can have several benefits. Participants may become more aware of their own psychological processes and feelings (Graham, Gask, Swift & Evans, 2009; Peschel & Peschel, 1993; Rabin, Matalon, Maoz, & Shiber, 2005) as well as their own blind spots (Lustig, 2006). They may be able to use their own feelings as a tool to better understand challenging patients, their behaviour and symptoms (Lustig, 2006). The presenter may benefit from finding a more helpful way of viewing and interacting with a particular patient, while the group members may be able to reflect on the patient in different ways, and their own experiences which may resonate with the presentation. Balint groups foster reflective thinking and may result in a better and deeper understanding of the doctor-patient relationship (Graham et al., 2009; Peschel & Peschel, 1993; Roberts, 2012). They also

have the potential to prevent compassion fatigue and burn-out and may increase job satisfaction (Bar-Sela, Lulav-Grinwald, & Mitnik, 2012; Benson & Magraith, 2005; Kjeldmand & Holmström, 2008; Rabin et al., 2000; Rabinowitz, Kushnir, & Ribak, 1996). These are all important factors when considering the potential use of Balint groups throughout medical training, and in ongoing clinical practice.

In the United Kingdom and Ireland, Balint groups are commonly part of postgraduate psychiatric training, and participation in reflective practice groups is mandatory for core trainees in Psychiatry. In the United States a large number of family practice residencies have incorporated the Balint group model into their curriculum (Johnson, Brock, Hamadeh, & Stock, 2001). In Germany, Balint group participation is part of undergraduate medical education (Salinsky, 2002) and Balint groups have also been introduced into the undergraduate medical curricula of universities in other countries, such as France, Italy, Switzerland, Austria, Poland, Sweden, Finland, South Africa, Australia, Peru, Brazil, the United States and the United Kingdom (Shoenberg & Yakeley, 2014). The UK Medical School Psychotherapy Scheme Working Group established in June 2014 has developed (or plans to develop) student psychotherapy schemes in 12 medical schools across the United Kingdom, with an aim to establish Balint groups in all 45 UK medical schools by 2017 (Johnston, 2014).

Aim and objectives

The scientific literature on Balint groups in general and medical student Balint groups in particular is scattered and there is little current literature relating to outcomes (Van Roy, 2015). The aim and primary objective of this review is to identify the potential benefits (outcomes) of medical student (population) Balint group participation (intervention) by reviewing the current literature on the topic. Secondary objectives of this review are to identify any other outcomes, challenges and/or limitations associated with medical student Balint group participation, and to discuss the current gaps in existing literature that may inform future research.

METHODS

A thorough search of literature was performed using the search terms 'medical students' (population) and 'Balint groups' (intervention) in the following databases: PubMed, PsycINFO, EMBASE and CINAHL. All literature up until May 2016 was considered and no restriction was set for the year of publication. Titles and abstracts for all articles were screened and potentially relevant articles were acquired and evaluated for eligibility. Non-English language articles, conference abstracts, book reviews and books were excluded. The search was supplemented by hand-searching the reference lists of all included articles and citation tracking.

A data extraction form was developed and used to extract data on study characteristics and methodology, participants (number of students and year of training), groups (number of groups, number of students per group, number of leaders, duration of session, number and frequency of sessions, and nature of participation), outcome measures/evaluation used and actual outcomes (including benefits, challenges and/or limitations of participation).

Heterogeneity allowed only for narrative synthesis.

RESULTS

The results are summarised in Tables 1 and 2.

The database search yielded 73 results in total. After removing duplicates (n=28), non-English language articles (n=15), book reviews and chapters (n=4) 26 articles remained. These were screened for eligibility and eight eligible articles were identified. Hand searches and citation tracking yielded four additional articles, which were included. In total, 12 articles were included in the review.

The majority of the non-English language publications were either in German (n=7) or in French (n=5).

Table 1 Summary of included articles

Article	Study characteristics/ methodology	Participants' year of training	Total number of students	Number of groups	Number of students per group
(Levenstein, 1981)	Descriptive article	5th year	5-6	1	5-6
(Levenstein, 1982)	Descriptive article	6th year	5-6	1	5-6
(Brazeau, Boyd, Rovi, & Tesar, 1998)	Quantitative methodology	3rd year	161	16	10
(Shoenberg & Suckling, 2004)	Quantitative methodology	3rd year (of a 5-year course)	9	2 initially, merged into 1 after 4th session	4-5 initially, 9 after 4th session
(Torppa, Makkonen, Mårtenson, & Pitkälä, 2008)	Qualitative methodology (grounded theory)	3rd to 6th year	9	2	4-5
(Yakeley, Shoenberg, Morris, Sturgeon, & Majid, 2011)	Quantitative methodology (RCT)	3rd year (of a 5-year course)	20	2	10
(S. Parker & Leggett, 2012)	Quantitative methodology	3rd year	20	2	10
Perry et al., 2013	Quantitative methodology	4th year	68	5	10-15
(S. D. Parker &	Mixed methods, incl. qualitative methodology	3rd year	42	5	8-10

Leggett, 2014)	(grounded theory)				
(Airagnes et al., 2014)	Quantitative methodology (controlled trial)	4th year	34	4	8-10
Atkinson & Rosenstock, 2015	Quantitative methodology	3rd and 4th year	10	1	10
O'Neill et al., 2015	Quantitative methodology	3rd year	6	1	6

Table 2 Characteristics of the groups

Article	Number of leaders	Duration of session	Number and frequency of sessions	Nature of participation	Outcome measures/ evaluation process
(Levenstein, 1981)	1	75 minutes	Weekly sessions over 6 months	Optional	Students' report
(Levenstein, 1982)	1	90 minutes	Fortnightly sessions over 10 months	Optional	Students' report
(Brazeau, Boyd, Rovi, & Tesar, 1998)	2	60 minutes	4 weekly sessions	Optional	Ad-hoc evaluation questionnaire (after)
(Shoenberg & Suckling, 2004)	2	Not stated	13 weekly sessions (overall 17 sessions, as initially 2 groups)	Optional	Ad-hoc questionnaire (before & after)
(Torppa, Makkonen, Mårtenson, & Pitkälä, 2008)	2	90 minutes	10 fortnightly sessions (group 1), 5 weekly sessions (group 2)	Optional	Grounded theory-based approach on fieldnotes
(Yakeley, Shoenberg, Morris, Sturgeon, & Majid, 2011)	2	Not stated	12 weekly sessions	Optional	Ad-hoc questionnaire (before & after)
(S. Parker & Leggett, 2012)	2	60 minutes	6 weekly sessions	Compulsory	Ad-hoc evaluation questionnaire (after)
Perry et al., 2013	1	Not stated	Fortnightly sessions over a semester (approx. 10)	Compulsory	Ad-hoc questionnaire (before & after)

					Competence & readiness questionnaire
(S. D. Parker & Leggett, 2014)	2	60 minutes	6 weekly sessions	Compulsory	Grounded theory-based approach on written feedback Ad-hoc evaluation questionnaire (after)
(Airagnes et al., 2014)	1	120 minutes	10 weekly sessions	Optional	IRI (pre & post) Ad-hoc questionnaire (before & after)
Atkinson & Rosenstock, 2015	1	60 minutes	8 fortnightly sessions	Optional	Ad-hoc questionnaire
O'Neill et al., 2015	2	90 minutes	6 weekly sessions	Optional	Ad-hoc questionnaire (before & after) Essay

Study characteristics/methodology

Most of the articles included in this review used quantitative methodology. Of those, one was a randomised controlled trial (RCT); there was also one non-randomised controlled trial. Two articles used qualitative methodology (both using a grounded theory approach). Two articles were descriptive.

The RCT included three groups: a Balint group starting at baseline, a Balint group starting at three months and acting as partial controls and a student psychotherapy scheme group (acting as control).

Participants and groups

The students' year of training ranged from the third (first clinical) year to the final year of undergraduate training.

The majority of the articles evaluated more than one Balint group and the total number of participating students varied greatly ranging from 5-6 to 161. The number of students per group ranged from 4-5 to 10-15. In most of the articles, there were two leaders per group. The duration of the sessions ranged from 60 to 120 minutes. The groups met either on a weekly basis or every other week. The total number of sessions ranged from 4 to 12. One group met over two years (but with long breaks included in this time period).

Attendance in most groups was optional. Most groups were offered to students irrespectively of their placement/rotation. Brazeau et al. evaluated groups offered during the students' rotation in general practice (family medicine), whereas Parker and Leggett evaluated groups offered during the students' rotation in psychiatry.

Outcome measures/evaluation process

Most of the quantitative articles used ad-hoc non-validated questionnaires as outcome measures. Yakeley et al. used a questionnaire testing the students' knowledge of emotional and psychodynamic aspects of the doctor-patient relationship. Perry et al. used both an ad-hoc and a competence and readiness questionnaire. Airagnes et al. used both the IRI scale and an ad-hoc non-validated questionnaire, which allowed students to rate their emotional responses to two case reports.

Torrpa et al. used a grounded theory-based approach on field notes collected during Balint groups. Parker et al. used a grounded theory-based approach in analysing written feedback provided by the participants.

Levenstein's evaluation comes from the written reports provided by the students. O'Neill et al. also used students' essays as an evaluation tool.

Benefits

The benefits of participation in a Balint group were reported by the students in each article and were identified by the authors for further discussion.

Most students rated their experience of participation in a Balint group as a positive and beneficial one. In particular, they reported positive value in both the process and the discussion about feelings related to patients and their own role.

Some students reported increased understanding of the doctor-patient relationship. Levenstein found that participation increased students' understanding and effectiveness in the doctor-patient relationship. Torrpa et al. argue that these discussions may be of educational value and that Balint groups support students' professional growth process. Yakeley et al. found that participating students demonstrated increased knowledge of the doctor-patient relationship compared with the control group. Airagnes et al. found that participation in Balint groups may increase students' ability to demonstrate empathy and enable them to "better handle difficult clinical situations, such as those presented by borderline personalities". Perry et al. found that the students, despite being sceptical at first, were able to feel comfortable opening up within the group, and felt that a trustworthy relationship had formed in which they could talk about their feelings.

Challenges and limitations

Parker and Leggett report students' uncertainty about whether Balint groups are relevant to their clinical practice and educational needs (at their level of training) due to limited clinical exposure. Brazeau et al. also acknowledged limited clinical exposure as a challenge making particular reference to the groups conducted during the earlier part of the student year. Similarly, Shoenberg and Suckling identified that students do not have sustained contact with

patients, and this may be a challenge when thinking about cases that might be brought for discussion.

Brazeau et al. and Parker and Leggett also reported that some students described the experience as a "waste of time" and rated it negatively. Parker and Leggett also identified that some students might have struggled to understand the process of a Balint group, and this may have inhibited their ability to benefit from attending such a group. Perry et al. also found that some students struggled with the perceived lack of structure and formality which is inherent to the group process.

Shoenberg and Suckling report that in the initial sessions the discussions were more general, and did not display a deeper understanding or context compared to later sessions.

Parker and Leggett describe students' difficulty to focus on relational issues as an additional challenge for the leaders. Perry et al. found that some students were keen to choose group members according to their natural social milieu, and felt that being part of a group which had been allocated to them might impede their ability to express their feelings.

Levenstein mentions students' immaturity and their potential for trying to use the Balint group as their own therapy, rather than focusing on their relationship with the patient; however, this did not occur in his experience of student groups.

Other outcomes

Torrpa et al., Brazeau et al. and Shoenberg and Suckling discuss the themes inherent in the cases that were presented in the group. Torrpa et al. identified four main discussion themes: feelings related to patients, building professional identity, negative role models, and co-operation with other medical professionals. Brazeau et al. and Shoenberg and Suckling report that most group discussions focused on feelings related to patients, while a few focused on the role of the medical student. Torrpa et al. have also explored triggers and contexts relating to the presented cases.

Brazeau et al. and Shoenberg and Suckling reported that the group leaders had found the experience of leading Balint groups gratifying and rewarding.

DISCUSSION

In general, Balint groups were well-received and well thought of by medical students.

Specific benefits reported include a deeper understanding of the doctor-patient relationship, feeling comfortable sharing their own feelings and an increased ability to demonstrate empathy, and contribution towards the students' professional development. These benefits might indicate that Balint groups should be seen as an important part of undergraduate medical training, as they offer a unique insight into a doctor's relationship with their patient which may lead to participants developing into more effective and intuitive clinicians.

Several limitations and challenges have been identified by the authors of the articles included. These were associated mostly with limited clinical exposure and the process of the groups.

Limited clinical exposure was identified as a potential challenge by several authors. It is worthwhile mentioning that these authors evaluated groups offered to third or fourth year students and that these groups were of short duration. In particular, Parker and Leggett evaluated groups offered to fourth year students for six weeks during their rotation in Psychiatry, whereas Brazeau et al. evaluated groups offered to third year students for four weeks during their rotation in general practice. Levenstein and Torrpa et al., who evaluated groups offered to fifth and sixth year students, did not report limited clinical exposure as a challenge. As the limitations relating to lack of clinical exposure were particularly noticed in the groups conducted earlier in medical training, this might indicate that benefits of Balint group participation would be maximal towards the end of undergraduate training.

As far as the group process is concerned, it was generally felt that students engaged well and were amenable to the way the Balint groups were set up. However, there were some who struggled to understand the processes, or felt that they were of limited benefit to their training. For this reason it might be helpful to consider an introduction to the method for future groups, to explain the rationale for the processes within the group, and the potential benefits professionally of attending a Balint group.

It is also interesting to note that students' participation in the groups evaluated by Parker and Leggett was compulsory and this may explain why these authors received more negative feedback from participants than in other studies. On the other hand, there is a risk of sampling bias inherent to the evaluation of groups where the participation was optional.

Methodological considerations

A main limitation of this review is that only English language articles have been included. As mentioned above, the database search yielded 73 results. Of those, 15 articles were in languages other than English, mostly in German (n=7) or in French (n=5). Balint groups have been introduced into the student medical curricula of universities in many non-English speaking countries, such as Germany, France, Italy, Switzerland, Austria, Poland, Sweden, Finland, Peru and Brazil (Shoenberg & Yakeley, 2014) and the majority of articles from these countries are in their native language.

Books and conference abstracts and proceedings have also been excluded from the review. However, their content has been considered during the discussion. There was no formal study quality assessment conducted, as it was felt that this may have reduced the number of articles needed to make this review meaningful.

Implications

This literature reviewed suggests that Balint groups may be beneficial to undergraduate medical students, particularly towards the end of their training. The benefits for group participants identified by this review included an increased capacity for empathy, a better understanding of the doctor-patient relationship and an aptitude for professional development. Balint groups are currently being introduced to a number of undergraduate medical programmes, with a plan for their introduction to 45 medical schools in the UK by 2017. It will be helpful to gather qualitative feedback as well as objective outcome measures from the students and leaders in each area. This will provide a larger sample size and

hopefully will demonstrate generalisable evidence in support of student Balint group attendance.

Looking at the evidence used in this literature review, if students are going to be offered an experience of a Balint group for a short time during their training, it seems likely that they will benefit from this most towards the end of their undergraduate degree. It might be that if outcomes continue to be positive as Balint groups are more widely rolled out across the UK, they might be available throughout the student's medical training, or certainly from the point at which students are having regular clinical contact with patients. In this case it will be important for the group leaders to have an awareness of the developmental level of the group in terms of their training, and to adapt their leadership styles accordingly.

In terms of future research it would be helpful to have generalisable outcome measures across centres that include both objective and qualitative feedback questionnaires. This will ensure that a larger overall sample size can be looked at in terms of benefits, limitations and challenges of running medical student Balint groups. It might also be helpful to think with group members and leaders about the group process i.e. how the group is set up and led. This might help leaders and supervisors to think about their approach, what might be helpful and unhelpful to the students at different times in their training, and how they accommodate the developmental level of group members in terms of their training.

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HOW BENEFICIAL ARE BALINT GROUPS

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Abstract

Participation in Balint groups is obligatory for training for some specialties in some countries However, there is a substantial lack of empirical evidence of Balint group effects. This study reports on the development and validation of a questionnaire aiming at the identification of processes in Balint group work.

The questionnaire is based on data calculations from two pilot studies resulting in a 17-item group questionnaire (BG-Q) covering perceptions and impressions of participants of a preceding Balint group session. The final factor structure of the questionnaire was derived by explorative and confirmative factor analyses based on data from a sample of 1635 Balint group participants. A three-factor solution resulted which could be assigned to four out of five latent dimensions of Balint's theory of group work with physicians. Scale 1 covers "Reflection of Transference Dynamics in the Doctor-Patient Relationship", scale 2 specifies "Emotional and Cognitive Learning", while scale 3 measures "Case Mirroring in the Dynamic of the Group".

Using mixed model analyses we examined the predictive value of the independent variables Sex, Age, Basic Medical Specification, Experience in Balint groups (in years), Clinical Experience in General (in years), Case Presentation vs. Non-Presentation, Facultative vs. Obligatory participation (Status) with regard to the dependent variables Scale 1-3. Mixed model analyses were calculated separately for the sub-groups Balint Experience < 1 year (vs. > 1 year) and for Balint Experience < 2 years (vs. > 2 years).

Complete data of all included variables were available for 1400 doctors. In Scale 1 "somatic" doctors score significantly higher compared to "psyche"-doctors. Case presenters score significantly higher compared to non-presenters. In Scale 2 "somatic" doctors show highly significantly higher scores compared to "psyche"-doctors. Case presenters also score significantly higher compared to non-presenters. Doctors with < 2 years of Balint group experience have significantly higher scores compared to those with > 2 years. In Scale 3 case presenters score significantly higher compared to non-presenters. Group participants with less Balint group experience (< 1 year) have significantly lower scores in Scale 3 compared to group participants with more experience with Balint groups (> 1 year).

Participation in Balint groups generates important effects on doctors' knowledge regarding the doctor-patient relationship both privately as well as professionally. These results confirm

generally accepted effects of Balint groups, thus providing empirical evidence for the importance of Balint group experiences for professionals in the medical field.

Keywords

Balint group – Balint group effects – doctor-patient relationship – group process – self experience

Introduction

Interpersonal skills and reflecting competences regarding the doctor-patient relationship should be essential for all medical professionals. Nevertheless the theory and practice of interaction is an ongoing challenge for medical education and training of specialists. Since psychoanalysis and psychosomatic medicine evolved, we know about the reciprocal enrichment and the complex interactions between body and soul which constitute the basis of all health conditions. In the 30s of the last century it was a famous German physician and philosopher, a specialist in neurology and internal medicine, Victor von Weizsäcker who demanded the *Reintroduction of Subjectivity* as a basic condition in medicine and healing. Michael Balint was a contemporary of Victor von Weizsäcker and it became his personal goal to investigate the importance of reflected subjectivity in a doctor-patient-relationship. His group method of guided interaction between health professionals based on a professional relationship with patients or clients became a standard for the development of future methods in group supervision (Balint, 1957; Balint and Balint, 1961; Mattke and Strauss, 2012).

For nearly 50 years there have been a lot of efforts to prove the effectiveness of Balint work (Joyce, 1970; Woodcock, 1970; Zabarenko et al., 1968). Some studies demonstrated increased capacity for empathy and changes in the conversational behaviour, along with readiness to listen to the patient more and talk less themselves (Cataldo et al., 2005; Kutter, 1990; Obliers et al., 1996). Positive effects were also discovered in some of the controlled studies, which included doctors who didn't participate or had not yet participated in the Balint groups (Adams et al., 2006; Johnson et al., 2003; Kjeldmand et al., 2004; Rabin et al., 2009; Turner and Malm, 2004). The changes observed were related to the increase of psychological and medical skills as well as self-confidence, better perception of patients, higher job satisfaction and indication of better doctor-patient interactions, and last but not

least significant decreases in burnout (Bar-Sela et al., 2012; Benson and Magraith, 2005). Limitations in previous research were due to small sample sizes and retrospective assessment of the participants instead of differentiated information on the participants during their participation in Balint groups. Since Michael Balint demanded continuous "training cum research", today there is still a mutual consent that further research is needed (Balint, 1969).

Method

Some five years ago we started with the idea to develop a questionnaire specific for Balint group work. Based on an extensive literature review we identified five theoretical dimensions to cover characteristic processes in Balint group work (Rosin, 1989; Rosin and Heigl-Evers, 1988).

1. Learning regarding the doctor-patient-relationship
2. Diagnostics of the doctor-patient relationship (dynamics of transference and countertransference)
3. Mirroring of the presented case in the dynamic group processes
4. Becoming aware of the doctor's own part in the doctor-patient relationship
5. Importance of interventions by the Balint group leader

We then developed a pool of 50 items covering these theoretical dimensions and tested them in two pilot studies. The first pilot study included six Balint groups with a total of 91 participants. In the second pilot study 294 doctors participated. Using feedback from the participants and further statistical calculations, we ended with a 17-item questionnaire which then had to be tested and validated with a large sample. Through the German Balint Society we contacted 147 certified Balint group leaders. Over a period of 15 months 107 Balint group leaders applied our Balint Group Questionnaire (BG-Q) in a total of 352 different Balint groups. Finally we collected questionnaires from 1635 Balint group participants. 1459 of them were medical doctors and 176 other health professionals. Each of them filled in the questionnaire only once directly after finishing a Balint group session.

Results and Discussion

Our sample of Balint group leaders showed a mean experience of 16.5 years Balint leadership and a mean of 33 years in professional work experience. Thus this sample of Balint group

leaders is a very experienced one. The average age of the participating doctors was 44 years, 65.5% (N = 955) of them were women, 33.5% (N = 504) of them were men. The mean work experience was 14.9 years, with a mean Balint group participation ranging around 4.5 years. Around 50% of all participants had less than one year of experience of participation in Balint groups. 72.9% (N = 1064) of the participants were somatic doctors and 23.3% (N = 340) were psychiatrists, psychosomatic medicine specialists and psychotherapists. One should note here that the participation in Balint groups in Germany is an obligation not only for psychotherapists and psychiatrists but also for general practitioners, gynaecologists and doctors working in pain units.

Most of the participants were general practitioners (33.2%), with 13.9% and 11.6% being therapists and gynaecologists respectively. Table 1 provides an overview of the participants' key medical professions.

Discipline	N	Percent
General Practitioner	485	33.2
Anaesthetist	20	1.4
Ophthalmologist	3	0.2
Surgeon	8	0.5
Dermatologist	10	0.7
Gynaecologist	170	11.7
Haematologist	3	0.2
ENT specialist	10	0.7
Internal Medicine	204	14.0
Paediatrician	113	7.7
Orthopaedist	17	1.2
Psychiatrist	216	14.8
Psychosomatic specialist	76	5.2
Psychotherapist	47	3.2
Pain Therapist	6	0.4
Urologist	9	0.6
Dentist	2	0.1
Missing	60	4.1
Total	1459	100.0

Table 1   Occupational Affiliations   (N = 1459)

To check the fit between the dimensional structure of our questionnaire and the theoretical working dimensions assumed by the reviewed literature we calculated an explorative and a

confirmatory factor analysis using a structural equation modelling. This resulted in a 3-factor-solution with an elimination of four of the 17 items (Figure 1).
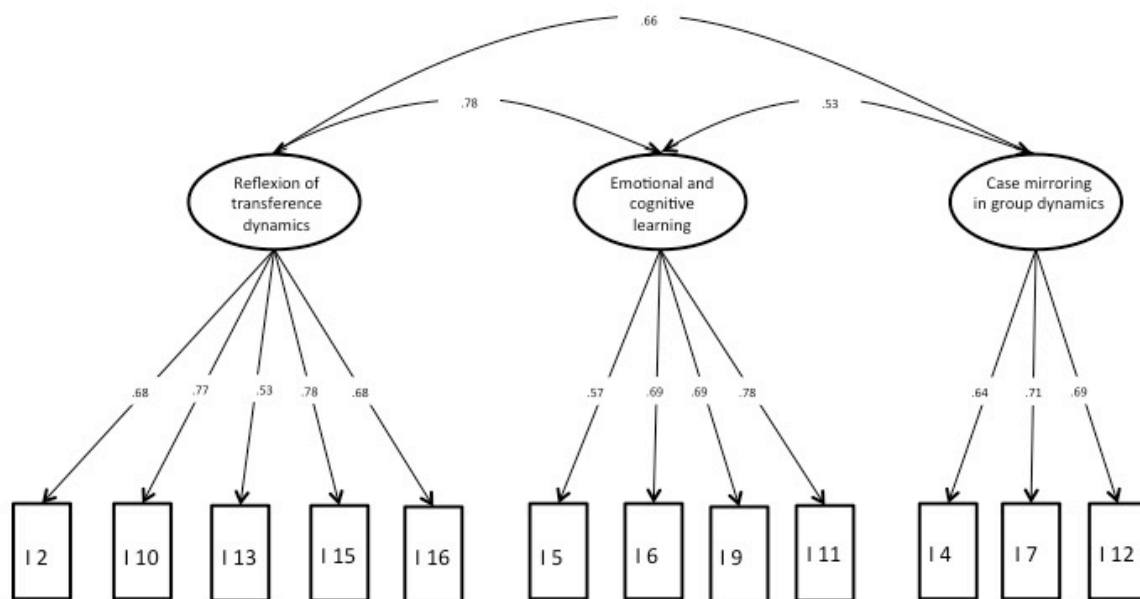

Figure 1.   Final Model of the Confirmatory Factor Analysis with Corresponding Items

The fit indices of the resulting model from the confirmative factor analysis range within a good and excellent spectrum (CFI = 0.97, RMSEA = 0.054 and SRMR = 0.033) (Flatten et al., 2017).

We could apportion the items loading on the same factor to the three scales as follows:

Scale 1 covers **"Reflection of transference dynamics in the doctor-patient relationship".**

Items in Scale 1:

     In today's Balint session…

1. 2. ...it became clear to me that subconscious affects can have a strong impact on the therapeutic relationship

    10. ...I recognised how much the therapeutic process is influenced by my own

subconscious reactions

13. ...the doctor's own part in the course of treatment and in the doctor-patient relationship were made a subject of discussion

15. ...I was made aware of how very much therapeutic relationships are shaped by previously unnoticed emotion

16. ...I came to understand how very much my own opinion about the patient affects the patient's course of treatment

Scale 2 specifies **"Emotional and cognitive learning"**.

Items in Scale 2:

In today's Balint session…

5. ...I was emotionally relieved by the casework

6. ...I gained new insights and understanding

9. ...I developed different perspectives on the case and therefore gained an entirely new view of the doctor-patient relationship

11. ...I received important insights and inspiration for my future work with patients

Scale 3 measures **"Case mirroring in the dynamic of the group"**.

Items in Scale 3:

In today's Balint session…

4. ...the group discussed the extent to which the group atmosphere is time and again influenced by the dynamics of the patient case

7. ...I became aware of how much the dynamics of a presented case had an impact on the atmosphere of the group discussion

12. ...the group was able to observe how each case triggered various kinds of reactions in various group members

Item 17 was excluded from the scale construction as it asks for a personal and general assessment regarding the previous experienced Balint group work and thus serves as a general evaluation item.

17. ...I enjoyed our work on doctor-patient relationship

Since our data structure includes different Balint groups led by the same Balint group leader we also had to test our data regarding fixed or random effects evoked by the person of the group leader. For this we calculated an additional confirmative factor analysis using only one participant of each group resulting in a subsample of 352 participants of the 352 participating Balint groups by calculating linear mixed model-analyses using a random effect test regarding the person of the group leader. No different factor structure emerged.

The BG-F was furthermore cross-validated with the Group Self-Experience Questionnaire (G-SEF) using a subsample of 255 participants of Balint groups, resulting in satisfactory convergent and discriminant validities.

As a first conclusion we can state that the resulting three-factor solution can be assigned to four out of the above mentioned five dimensions of Balint's theory of group work with physicians.

Surprisingly all items designed to test the influence of interventions by the Balint group leader were eliminated during the two pilot-studies so that our 17-item questionnaire doesn´t cover and can´t confirm the hypothesized theoretical dimension "Importance of interventions by the Balint group leader". This might be due to insufficient phrasing of the initial items or perhaps it mirrors the subjective impressions of the doctors participating in the pilot studies that there was no influence by the group leader.

Nevertheless our personal opinion regarding this aspect is that group leader interventions have an important impact on group processes. More research in this regard is needed.

As a second target for analysing our data set we decided to examine the influence of several variables on the values of the above assigned dimensions of Balint group work. The

following variables were tested as independent variables (predictors) in terms of scale values (as dependent variables) for mixed model analyses:

- gender and age
- main profession (somatic doctors as opposed to psychotherapists)
- years of professional experience
- years of Balint group-related experience
- status of participation (voluntary participation as opposed to mandatory group participation)
- clinical cases (presenters of own patient cases as opposed to non-case-presenters).

For example we wanted to know whether it makes a difference when a doctor participates in a Balint group because he is obliged to do so for his medical training as a specialist or if he does it on a voluntary basis. Another target aimed at the question whether a doctor who has no training in psychodynamic reflections, like most doctors in somatic disciplines do, might have greater gains regarding emotional and cognitive learning from their participation in Balint groups. Likewise it would be important to know better about the different perception between those participants who present a case and those who act as normal group members by listening to the case presentation of another group member. And in the end, do the years of professional work experience or of Balint group experience impact scale scores?

Predictor	Estimation	SD	df	T	p
Constant Term	3.330118	.198349	1.343	16.789	,000
Sex	.071685	.050028	1.343	1,433	.152
Age	.001721	.005382	1.343	.320	.749
Profession	.125013	.125013	1.343	**2.277**	**.023***[*]
Status	- .097526	.058071	1.343	**- 1.679**	**.093**
Case Presenter	.136718	,054351	1.343	**2.515**	**.012***[*]
Professional Experience	- .005026	.005565	1.343	- .903	.367
Experience in Balint Groups	.056965	.063080	1.343	.903	.367

Table 2   Mixed Model Analysis –

Dependent Variable: *Reflection of Transference Dynamics in the doctor-patient relationship* (Scale 1)

[*] $p < .05$

Predictor	Estimation	SD	df	t	p
Constant Term	2.931691	.225246	1.343	13.016	.000
Sex	.086298	.056812	1.343	1.519	.129
Age	- ,003174	.006112	1.343	- .519	.604
Profession	.186076	.062336	1.343	**2.985**	**.003**[**]
Status	- .133415	.065946	1.343	**- 2.023**	**.043**[*]
Case Presenter	.629325	,061722	1.343	**10.196**	**.000**[***]
Professional Experience	- .003174	.006320	1.343	- .519	.903
Experience in Balint Groups	.185720	.071633	1.343	**2.593**	**.010**[**]

Table 3   Mixed Model Analysis –

Dependent Variable: *Emotional and Cognitive Learning* (Scale 2)

[*] p < .05   [**] p < .01   [***] p < .001

Predictor	Estimation	SD	df	t	p
Constant Term	3.558487	.237080	1.343	15.010	.000
Sex	.013934	.059797	1.343	.233	.816
Age	- .002465	.006433	1.343	- .383	.702
Profession	- .089519	.065611	1.343	- 1.364	.173
Status	- .112245	.069411	1.343	- 1.617	.106
Case Presenter	.189166	.064965	1.343	**2.912**	**.004**[**]
Professional Experience	.000628	.006433	1.343	.094	.925
Experience in Balint Groups	- .109855	.075397	1.343	- .383	.702

Table 4   Mixed Model Analysis –

Dependent Variable: *Case Mirroring in the Dynamic of the Group* (Scale 3)

[**] p < .01

As Tables 2, 3 and 4 demonstrate we find several predictors which prove to have a significant effect on scale scores. For example:

Scale 1 *Reflection of Transference Dynamics in the doctor-patient relationship* shows a significant prediction effect by the variables profession and case presentation.

This means that somatic doctors who fall short in psychodynamic training skills present with higher scale scores compared to "psychic doctors" who may, based on their training, be more used to reflect the doctor-patient relationship. Also we can prove that those 352 doctors who presented a case show significantly higher scale scores as an expression of greater gain from the group work.

Scale 2 *Emotional and Cognitive Learning* demonstrates significant effects for the variables status, profession, case presenter and experience in Balint work.

Again this means that somatic doctors and case presenters show up with higher learning gains. But this is also true for doctors who participate on a voluntary basis. Finally, those participants who have less than two years of Balint experience reveal greater effects regarding emotional and cognitive learning.

Again, Scale 3 *Case Mirroring in the Dynamic of the Group* shows a significant effect for the case presenters. This result explains that doctors who can observe the group work from a more distant position can better identify mirroring aspects regarding the presented doctor-patient relationship and psychodynamic processes in the Balint group work.

It is not visible in this Table but if we divide the variable "experience in Balint work" in those with less than one year of experience and those with more than one year, we also find a significantly better identification of the mirroring aspects by the more experienced group.

In summary:

Balint group work deserves research and research may help us to understand more of the complexity which is characteristic for all group processes. Those doctors and therapists who

have experienced Balint group work before, usually assume that Balint group work can be a helpful method for all doctors working with patients. To implement Balint group work as a normal part of medical education we are in need of valid knowledge and research findings about the risks and the effects of the Balint method.

We were able to identify three dimensions of Balint group work

"Reflection of Transference Dynamics in the Doctor-Patient Relationship"

"Emotional and Cognitive Learning"

"Case Mirroring in the Dynamic of the Group"

These dimensions can be measured by a short 12-item questionnaire after any Balint session. The different scales prove to be sensitive to important differentiating variables that we have to manage with in medical education and training for specialists. Our results show that Balint group work produces greater measurable effects when it is applied to less experienced doctors. We found significant effects for somatic doctors versus psychic doctors and doctors with less experience in Balint groups. We found that obligatory versus facultative participation doesn´t produce important effects, apart from Scale 2 scores in "Emotional and cognitive learning". Here we observed a tendency for greater learning in the facultative group. This means that to participate in a Balint group produces effects irrespective of the reason why someone participates. The most impressive finding is the fact that a case presentation leads to the greatest effects in contrast to be just a listening member of the Balint group. These effects are consistent for all three scales. This means we should encourage the younger participants of Balint groups to present their own cases, thereby probably producing greater effects helpful for their medical training. Incidentally, this result is consistent with the findings of group therapy research that self-disclosure is one of the most effective group therapeutic factors (Tschuschke, 1993; Wampold and Imel, 2015).

The Balint Group Questionnaire (BG-Q) represents four of five dimensions of Balint work as they were assumed by previous theoretical considerations. Only the effects of interventions by the group leader could not be represented in the scale construction.

The development of the new Balint Group Questionnaire (BG-Q) is a helpful step for further research in the field and we should consider checking our findings in different Balint settings

and Balint cultures. The BG-Q is a validated, short, time-economic and easy to handle questionnaire in daily practice as well as in research. The Balint Group Questionnaire is available in a German, English and a Russian version.

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WORKSHOPS TAKING PLACE AT THE CONGRESS

1.WORKING WITH DIVERSITY AND DIFFERENCE IN BALINT GROUPS – THE PATIENT, THE CLINICIAN, THE LEADERS AND THE GROUP

Workshop facilitators Drs Jane Dammers, Ami Kothari and Judy Malone

This workshop will be an opportunity to explore the theme of the conference, looking at how diversity and difference is experienced and thought about in the work we do in Balint groups. We, clinicians and patients, bring an enormously rich diversity to the work and the relationships which we explore in our groups. These differences are interesting and lead to creative thinking and feelings. They can also lead to highly charged and difficult emotions which are hard to express and understand at times. Gender, class, caste, race, family and educational backgrounds, sexuality, creed, social status and so on affect how we perceive and relate to one another, as well as how we see ourselves. This is at an unconscious level much of the time, often based on early experiences. Uncomfortable and conflictual feelings and issues may well arise when we start to explore what identity, difference and diversity mean in relation to our work.

This 90 minute workshop will start with an introduction by the facilitators (max 10 minutes) and will then break into small groups, each facilitated by a member of the team. There will be an opportunity to come back together in the large group towards the end of the workshop and participants will be asked to complete a written evaluation.

We will ask participants to have in mind a Balint group session (not from this conference) where themes relevant to the workshop seemed to be important. Working with the material brought we will explore how issues of identity and difference were presented, experienced and discussed, or perhaps avoided, in the Balint group – differences between the presenting clinician and the patient, diversity among the group members and leaders. What creative tensions were discovered; what could not be talked about? What seemed to matter and what challenges were there for the leaders? There will be many questions which the groups will want to explore.

This is a relatively short workshop and our expectations should be appropriately limited. We hope to be able to facilitate conversations, ideas and dialogue around the issue of diversity, as it plays out in Balint groups, in a safe and contained environment. We expect the workshop will relate to other presentations at the conference and will be an opportunity to explore some of the ideas and issues coming up in more depth. With participants at the IBF conference coming from diverse backgrounds, cultures, countries and professions we can look forward to an interesting and stimulating experience together.

Preferred number in workshop 8 per small group with a maximum of 10 per small group. It would be helpful to have break out rooms for the small groups is possible. We would like to be in touch with participants some time before, so that they have time to think about a Balint session they would like to bring.

2. BALINT THEORY AND PRACTICE: EXPLORING THE INTRODUCTION OF BALINT GROUPS FOR HEALTH PRACTITIONERS WORKING WITH PEOPLE FROM DIFFERENT CULTURAL AND ETHNIC MINORITY GROUPS

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1. **Learning objectives**

By the end of the workshop participants will:

   a. Have identified the benefits and explored the challenges in introducing Balint groups to health practitioners working with people from different cultural and ethnic minority groups. Examples being health care workers working with migrants, refugees or other communities including Indigenous people
   b. Understand the concept of cultural safety as it applies to working with different cultural and ethnic minority groups
   c. Have considered how the history of different cultural and ethnic minority groups may influence the cross-cultural Balint group experience
   d. Considered how vicarious trauma can be minimised for people participating in Balint groups that involve different cultural and ethnic minority groups

2. **Program outline**

   a. Introductions – name, country, Balint group settings 10 MINUTES
   b. Description of the learning objectives 5 MINUTES
   c. Talk on the Australian experience of Balint groups with Aboriginal cultural educators for doctors working in remote Aboriginal communities. Explain how this can be used as an example of working with different cultural and ethnic minority groups 10 MINUTES
   d. Participants are invited, in groups of five, to describe their experiences of working with different cultural and ethnic minority groups and any related Balint group experiences. 15 MINUTES
   e. Talk on cultural safety and vicarious trauma 5 MINUTES
   f. Participants are invited to explore, in the same groups of five, how the history of different cultural and ethnic minority groups may influence the cross-cultural Balint group experience. The group also to look at ways to maximise cultural safety and minimise vicarious trauma in these circumstances. 15 MINUTES
   g. Small groups give five-minute presentations to the large group. 25 MINUTES
   h. Summary and closure of the workshop 5 MINUTES

3.WHO HELPS THE HELPER?

THE OPPORTUNITIES OF AN ART THERAPY BALINT GROUP

Workshop: Dr. Fehér Pálma Virág Ph.D., Károli Gáspár University of the Reformed Church, Institute of Psychology, Department of Clinical Psychology, Budapest, Hungary, fp@feherpalmavirag.hu

The support of the helper in the Balint group is a topic which awoke the attention of the healers again in our everyday life. Previously the significance of the Balint group was mentioned in several forums where the efficiency of the prevention of burnout was emphasized.

This time we can look at the action of a certain Balint group in a different perspective. To be more precise we can support the helper how this becomes possible in a Balint group of art therapy.

The basic strength of the group is inherent in the way that the case presenter has an opportunity to connect the verbal dimension constructed well with questions and the dimension without words opened by the nonverbal techniques. The starting thought of the art therapy Balint group was based first of all on the experience gained from the doctor workshops preventing burnout, where I have used some nonverbal elements and art therapy techniques for the expression of the contents which are difficult to express with words.

During the workshop the group creates a shared piece of art using paint and collage. As a warm up we start with an MBSR meditation (mindfulness based stress reduction), which is a kind of wakeful meditation (5-7 minutes), then the case presenter will talk about a patient or client.

The first nonverbal creation phase comes after the questions. The second nonverbal creation phase follows after sharing the emotions and thoughts. During this phase the group members use only paints of different colours to express their emotions, body feelings, and impressions in connection with the case having been discussed beforehand. This will give a base for the piece of art by putting a first layer onto the canvas.

The next verbal phase is the sharing of ideas, thoughts and more emotions about the case. This lasts about 25 minutes.

After this verbal phase the leader would ask all the group members to shape their reflections from this last verbal phase onto the canvas as a next layer, over the paint 'patches' already seen.

At the end of the case discussion the leader asks the presenter to share their reflexions about what was said and what can be seen on the canvas formed into a piece of art, which now can be analysed just like a text.

Each of the non verbal phases takes about15 minutes.

The group represents the strengthening of the psychosomatic way of thinking in the traditional way which is the same as the Balint group. Its main topic is the formation of the doctor-patient relationship, its aim is to create the deeper understanding of the relationship dynamics.

Keywords: art therapy, Balint group, nonverbal techniques, understanding of the relationship dynamics.

4. WORKSHOP: DEVELOPING CULTURAL HUMILITY

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Katherine Knowlton, Ph.D. tryekk@aol.com

Cultural competence is best defined not by a discrete endpoint but rather by a commitment and active engagement in a lifelong process of self-reflection, self-awareness and conversation with others about their unique and different perspectives about health, illness and respectful health care.

This process might be best thought of as developing cultural humility, making the practitioner flexible and responsive to diverse people and situations. An awareness of one's own assumptions and blind spots is fundamental to developing cultural humility. This proposed series of participatory exercises is designed to support that development by helping participants become aware of aspects of their own cultural identities they may not have considered, but which may inform both patient care and Balint group leadership.

Exercise #1: On The Outside (25 minutes)
This exercise guides participants to explore the emotions that emerge in any of us when we feel like we are on the outside, excluded, less privileged or marginalized and how that might impact our functioning as a patient or group member.

Exercise #2: What's in a name? (25 minutes)
There is cultural, religious, personal and family meaning in each of our names. Participants will have an opportunity to reflect on (and share if they wish) their own names, their origins and meanings.

Exercise #3: Health Superstitions (25 minutes)
In every culture, families have and share superstitious beliefs about the causes and cures for all kinds of ailments. (e.g. an apple a day keeps the doctor away; "God bless you" keeps the devil away) Participants will be encouraged to reflect on, write about and share their own families' beliefs about health and illness.

Group Processing: (15 minutes)
The two leaders will facilitate a discussion about: how the increased awareness from these three activities might inform us as Balint leaders; how the exercises may increase our curiosity about our own cultural identities; and how what we have learned may encourage us to continue to explore the role of culture in medical care and relationships with patients.

5.BRINGING SEXUAL and GENDER DIVERSITY CASES AND DIVERSE SEXUALITY AND GENDER OF GROUP MEMBERS AND LEADERS INTO THE WORLD OF BALINT.

Workshop by <u>Timothy McMichael</u>, Auckland, New Zealand. E mail temcmichael@yahoo.co.nz

Based on his experience of running 10 groups over the past 5 years, and his participation in one intensive each year for the past 4 years, the presenter will share some of his experiences of coming from a sexuality minority background, and how his experience of even the subtlest, and probably unintended heteronormative assumptions have impacted on his work as a Balint Leader and as a Balint group member.

The presenter will share some ideas about making Balint groups more appealing to participants from sexuality minorities.

Using some sharing of research data, fun role plays, and earnest conversation, it is hoped that participants will feel more at ease with cases of a sexuality diverse and gender diverse nature being worked in Balint Groups, and will also reflect more on what might need to be done to make participation in Balint groups more appealing to potential members coming from sexual minority/gender diverse backgrounds.

Timings of the workshop

- Introductions and any necessary ground rules. (5 mins)
- Opening Circle individual statements about Gender Diversity and Sexuality Diversity (10 mins)
- Facts and figures - how accurate does our understanding need to be? A brief presentation (10 mins)
- Dummy case presentation (10 mins)
- Fishbowl working the case (15 mins)
- Brainstorming - identifying the issues - small groups then feedback in large group (10 mins + 10 mins)
- Brainstorming - coming up with solutions - small groups then feedback in large groups (10 mins + 10 mins)

6.STARTING A NEW BALINT GROUP – WHAT ARE WE TO EXPECT, AND IS IT WORTH THE EFFORT?

Amos Ritter (2nd presenter to be announced)

There are many challenges one has to expect when deciding to start a new Balint group. The first step is deciding on the group's structure and the setting of its activity. Should the group be multidisciplinary? How often should we meet? Where and when? What should be the length of the session? Should we have 2 cases or just one in each session? One leader or two? If two leaders – what should be the role of each leader? Should we ask the participants to pay for each session? If yes, how much? Should we run a "classic" group or create our own rules and techniques?

The goal of this workshop is to bring up the issues that are most relevant to the participants and discuss them, and this way learn from each other's experience.

In the workshop we will form a Balint group in which the "cases" will be recently started Balint groups which will be presented by the participants. The case history will relate to the forming of the group, from the initial idea till the first sessions, with emphasis on the difficulties they have encountered and how they have dealt with them. After the presentation, the group will relate to the "cases" and analyze the main issues just as is done in a regular Balint group. There will be 2 "cases", each 30 min. long, followed by a closing discussion of the entire process.

Presenters:

Amos Ritter, MD, MPH,Maccabi Healthcare services, north district, Haifa, Israel, amosrit@gmail.com

7.THE BALINT 2.0 INTERNET GROUP - AN INTERNET FISHBOWL WORKSHOP

<u>Albert Lichtenstein and Donald Nease as leaders and Andrew Elder as facilitator</u>

Balint 2.0 group members: Kyle Hoedebecke, Luis de Pinho-Costa, Maria Bakola, Marinela Chertsougk, Maria Colon, Susanne Cording, Vasiliki Gkarmiri, Nagwa Hegazy, Maha Obedoza, Ana Rochadel

The Balint 2.0 Internet Group continues its work as described and presented in the 2015 International Balint Congress in Metz. Balint 2.0 remains a strong collaboration between the WONCA Young Doctors Movement (YDM) and the International Balint Federation with strong participation from several YDM regions including Europe, Africa, North America, South America, and Asia. As such the group reaches a very ethnically and culturally diverse group of participants. We believe this novel format holds potential for allowing participation in a Balint Group for individuals that do not have access to a local group or trained leaders. Our group has continued to meet on a monthly basis, and in the Fall of 2016 we welcomed several new members as several original members had needed to leave the group due to moves or new jobs.

In order to further the understanding of this new format for convening and holding a group, we propose a fishbowl workshop with our usual Balint 2.0 group members and leaders running a 45 minute group internet session, after 5 minutes to introduce the session, followed by 25 minutes of facilitated discussion and a final 15 minutes to discuss potential expansion of the Balint 2.0 process and format. The internet group session will be projected so that workshop attendees can see and hear the group working just as if they were a normal participant or leader. Ordinary fishbowl and Balint group rules of confidentiality will be respected. In the event of technical difficulties with running and projecting a live group, a recording of a prior Balint 2.0 group session will be available, and we anticipate that several group members will be at Oxford to attend the workshop in person to allow interaction with other workshop attendees.

Topics which we hope to elaborate during the large group discussion include in addition to typical fishbowl elaboration of the group process: differences in leadership tasks for an internet group, holding the Balint frame, potential differences in benefits to group members, and group trajectory. Workshop participants will be encouraged to pose questions to the Balint 2.0 group members and leaders regarding the process.

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8.DEMONSTRATION BALINT GROUP:

Balint Society UK, Leaders to be announced

<u>Balint Fishbowl large group</u>

This group offers an opportunity to discuss the Balint group process following observation, or participation in, a live Balint group. Chairs are arranged in an inner circle of 10, with an outer circle of the remainder. Participants are invited to volunteer to sit in the inner circle to fill eight chairs, with two leaders completing the live group. The leaders then run a 45 minute Balint case, offered by a member of the live group. All those not in the inner group sit and observe in the outer circle, and do not speak during the case. At the end of the case, one large group is formed. Facilitators then guide a discussion of the group process, starting with observations from the case presenter, leaders and inner group members, then from anyone who wishes to contribute. We try not to go back into a discussion of the case itself, though this can be hard to resist!