



Balint
seeing medicine
through other eyes

Balint

21st International
Balint Congress
Porto, 2019



APGB
Associação Portuguesa
de Grupos Balint

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Biologist at CIIMAR (Porto) and plastic artist

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Indice

Congress Organising & Scientific Committee	08
What is a Window?	11
Cap. 01 Introduction	13
Reflections on the theme: Seeing medicine through other eyes	15
Balint work – the way of patience	17
Cap. 02 Orationis Sapientia	21
Hearing Secret Harmonies: Balint and the Re-imagining of Medicine.	23
Cap. 03 “The theory and structure of Balint Groups”	41
Seeing Future of Medicine Through Other Eyes	43
Balint’s Essential Creativity	50
Michael Balint: Early Interventions, Early Groups	57
Cap. 04 “Implementing Balint Groups in Medical Systems”	63
Seeing the Outline of a Star	65
Balint Infrastructure in a Large Tertiary Hospital In Israel A paper presentation for the Porto Balint conference.	72
Cap. 05 “Providing Support and Preventing Burnout”	81
Prevention of Professional Burnout in Psychiatric Hospital Medical Personnel: A Look at the Psychiatry Through Doctor-Patient Relationship	83
Testing Balint Boundaries – When the doctor’s feelings don’t fit well in a single case	94
Think Fresh - Is This Still Balint?	99
Cap. 06 “Students, Doctors and Patients”	109
Through the Eyes of Medical Students: Reflections on Suffering and End of Life Care.	111
Recovering the Healing and the Humanity in Medicine: Doctors and Patients in Conversation	119
Cap. 07 “Different views”	127
The Balint Group Seen Through the Pharmacologist’s Eyes	129
In Between Spaces - Strangeness and Togetherness in Balint Groups	135
Cap. 08 Ascona Prizes	145
Recreating Thoughts: The Person, The Illness or The Tattoo?	147
Mate	161
A Home Visit to Remember	169

Cap. 09 Papers Not Delivered in Congress	179
An Inter-Fenestration: How the Sounds of Words Frame What We Hear (and See) and How They Frame Us	181
Seeing the Doctor Patient Relationship Through Other Eyes With Balint Concepts: From The Basic Fault to Triangulation and Creativity	185
The Efficiency of the Balint Group Process in Case of Traumatic or Psychotic Structural Dissociation	192
Some Conditions for the Success of a Balint Group	197
Psychosomatic Medicine and Balint Group Work - Integration of Basic Principles and Practical Interaction	203
Cap. 10 Workshop's	209
The Art of Medicine: A Workshop to Help us See Through Other Eyes	211
Group Therapy, Group Supervision, Balint Group: Similarities and Differences.	213
The doctor and his patient, when the patient is a doctor	219
Explore the Mysteries and Magic of the Developing Co- Leader Relationship	220
Balint Group Co-Leadership - Opening a Window to the Group Work - Action Research	223
Cap. 11 Posters	227
“Balint-Like” Groups for Medical Students During Their 3 Years of Clinical Rotations - A Description of a New Project	229
Empathy in a Multicultural World: A Challenge for Balint Groups?	230
Themes of Intrapatient Existential Conflict in Four Years of Physician Balint Groups in a Rural American Residency Program: Moving Toward a Phenomenologic Tool to Address Early Physician Stress	231
Balint Groups in Medical Graduation: An Experience Report	233
“The Difficult Patient” - The Perspective of the Physician in a Balint Group Context	234
Is Balint Training Associated With the Higher Degree of Empathy Among Primary Health Care Doctors?	235
Bringing Balint Groups to Undergraduate Medical Education Poster	237
Balint Groups Implementation in Greece The First Reported Experiences	238
Farewell	243

Congress Organising Committee

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Senior Graduate General Practitioner, he lives and works near Porto, is a member of Balint groups since 2005, a group leader since 2008 and the president of the directive board of the APGB since 1st January 2014.

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General Practitioner in a health center near Porto, she participates in a Balint group since 2010. She belongs also to the APGB. This year she also began training in leadership.

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General Practitioner, the youngest member of the organizing committee, she works as a GP since 2016. She is a member of a Balint group since 2012, and now belongs to the directive board of the APGB.

Congress Scientific Committee

Andrew Elder, FRCGP DEd (Hon)

General Practitioner for 36 years in an inner London teaching practice, and retired in April 2008. He joined his first Balint Group in 1972 and worked with Enid Balint from 1977 until her death in 1994. He contributed to two books which arose out of research with Enid Balint – "While I'm Here, Doctor" (1987) and "The Doctor, the Patient and the Group" (1993). He was a consultant at the Tavistock Centre in London and was awarded an honorary doctorate in recognition of his work in mental health and primary care in 2017. Until recently he was co-ordinator of the International Balint Federation (IBF) leadership task force.

Heide Otten,

Born in 1944. Medical school in Göttingen and Munich/Germany, from 1964 to 1970. Doctoral thesis: Max-Planck Institut for Psychiatry, Munich, 1972. Specialization as a GP and in Psychotherapy. Working in private practice. In Balintwork since 1979. Balintgroup leader since 1987. Secretary of the German Balint Society from 1991 to 2013. President of the International Balint Federation from 2001 to 2007. Vice-President of Ascona Foundation. She wrote: "The theory and practice of Balint Group Work", Routledge, Abingdon, UK, 2018; "Leading a Balint Group", Psyllabus, Moscow, 2017; and papers about Balintwork in different journals.

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Graduated in Philosophy by the University of Lisbon in 1965. Several post-graduated professional training courses on Leadership and Conflict Management, more specifically since 1991 on Health Communication. From 2002 onwards have been working both as single and with a co.leader with Balint Groups, leading 5 groups, some of them during 10 years, within the context of family doctors inside the Portuguese NHS. In 2016 she started a monthly supervision of one Balint group. Research activity focused on the validation of the Jefferson Empathy Scale, before and after the participation in Balint Groups, and a longitudinal analysis of 87 cases over two years originated in the groups under her leadership.

What is a window?

José Tolentino de Mendonça

Translated from the portuguese original book: "O pequeno caminho das grandes perguntas".
Ed. Quetzal, 2017

What is a window? We can answer immediately, without thinking too much, and say that it is a simple thing: an opening ripped on a wall, to bring light and air into a certain space. But maybe it is not that, or just that, that makes a window so necessary. What makes it striking and unforgettable is that it is a sort of passage for the eye.

What is a window? It's a bridge between worlds, an invitation to the circulation of the real, a bond between interior and exterior, a close threshold to infinity – and our eye knows it well. A window leads us into the astonishment. In our lives there are windows that we remember, because through them we looked at the openness of life; through them, time, that mysterious and elusive element, has shown itself wholly in the transparency of the visible; through them we realize that what first seemed to us only a sensory perception of what is outside, was after all a precious probe for us to travel inwardly.

A window is an hermeneutic machine, a complex system of relationships, a model of knowledge. When we open a window, it opens on what? We are inclined to answer with the verses written by Rainer Maria Rilke, also in a question form: "Aren't you our geometry / window, so simple form / that effortlessly circumscribes / our enormous life?"

Cap. 01
Introduction

Reflections on the theme: Seeing medicine through other eyes

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"Seeing Medicine through other eyes." It is a beautiful theme with which our Portuguese hosts welcome and encourage us at this 21st International Balint Congress. It is a theme which speaks to the core values of the movement founded by Michael and Enid Balint over 60 years ago. As we open this Congress, I would like to offer a few reflections on the theme and its importance for our movement.

In order to see medicine through other eyes we must accept several ideas. First, we must accept the limitations of our our own eyes. We must humbly acknowledge our humanity. We must realize that our eyes sometimes deceive us. They miss important details. We have blind spots. Also, what our eyes see is interpreted through our own experience. A warm and loving face on a patient may remind me of my mother, but this is not my mother sitting across from me in my exam room.

Second, the eyes of medicine are also limited. A problem list which details the medical diagnoses faced and experienced by a patient represent a factual representation but they tell us nothing about who it is that bears these burdens. A blood glucose test or a depression measure tells us something important about the state of a person's diabetes or depression, but it tells us nothing about their ability to deal with either of these. Knowing a person fully requires other eyes.

Third, we must accept that we are not like the three blind men of India and the elephant, one of whom grabs the trunk and exclaims, "It is a snake", another of whom grabs the leg and says, "It is a tree!", and the third who touches the ear and says with authority, "It is like a leathery fan!" Medicine is more than just approaching healing by collecting the opinions of various specialists, who themselves are blind to everything outside their domain. No, the persons we treat are like complex tapestries, woven with many threads, of which symptoms and diagnoses form just a portion of the total.

Balint group work allows us to see Medicine through other eyes. As Balint practitioners we intuitively know the power that other eyes can bring to our work. In a Balint group the presenter cautiously entrusts their relationship with a suffering human to the group. In their humanity, the presenter is not able to fully see the person in front of them. The relationship and its healing potential is therefore unfulfilled. The Leader encourages the group members to bring their eyes to the relationship. What do you see? How would you see if you were the presenter? What might you see if you were the patient? What is in the way of your vision as the patient or the presenter? Group members respond with how they see things through their eyes. In effect, the presenter sees their practice of Medicine with this patient with "other eyes." As a result the next meeting with the patient is transformed and healing can be reached.

Our Balint work is not easy nor is it easily understood. We are in many ways against the mainstream of Medicine, which honors the keenly honed, mechanistic approach of microscopic, monocular vision. Yet, the most advanced physical sciences are more aligned with our approach. Is light a wave or a particle? That depends on your perspective. This is an established fact. Someday the rest of Medicine may realize the need for "other eyes" and their perspectives on the holistic reality of a human. So we keep on, striving, with the wisdom of our work being proved in our groups and consultation rooms.

The ongoing work of the International Balint Federation must be to continue to bring this well honed Balint process which allows us to see Medicine through other eyes to more and more healing professionals around the world. I am proud that we are advancing that work. We continue to welcome new Societies from around the world to our Federation. We are bringing Balint to young doctors who would otherwise not be able to belong to a Balint group. We are constantly seeking to improve the quality of our method by learning from each other. Our statutes echo this:

The goals of the IBF are:

1. to promote and develop Balint training and research thereby fostering the interests of humanistic, psychological and psychotherapeutic aspects of clinical practice
2. to disseminate this knowledge thus improving the care of the public at large.

In conclusion, as we pursue these goals, we dare not ever forget Michael Balint's words: "At the center of medicine there is always a human relationship between a patient and a doctor." Fully realizing the healing potential of that relationship sometimes requires that we allow ourselves to see through other eyes.

I welcome you to this 21st International Balint Congress. Deepen your vision of Medicine by seeing through the other eyes at this conference. And when you go home to your groups and your consultations, share the vision and share your eyes with others.

Balint work – the way of patience.

Manuel Mário Sousa, MD

Chairman of the Portuguese Balint Association

Dear colleagues,

Thank you very much for your participation in this International Conference. It's an important event for the Portuguese Balint Association and a great opportunity to let you know how very pleased we are to have you here with us in this beautiful city of Porto.

I welcome you and I kindly ask you to allow me to share my own Balint experience throughout my professional life. Consider this as a confession. Perhaps many doctors have felt and experienced the same.

Many years ago, when I was still a young doctor, I often felt complicated to understand some of the clinical situations that I was confronted, especially because I insisted on following religiously the clinical guidelines based on the bio-medical model, just as I had learned in the Medical School. This daily challenge weighed heavily on my shoulders, leaving me often stressed, worried and even unhappy with my practice. For a long time I tried to find the true meaning for my concerns and doubts related to my profession. I was seeking something specific, a process based on a different way of thinking, through a holistic and patient-centered perspective.

Fortunately, in the early nineties, still as a young family doctor, I had the opportunity to experience, for the first time, a Balint Group which I participated in for two or three years. After this short experience, a strange feeling began to emerge within me, some kind of phenomenon that existed concealed in the complex encounter between the patient and myself.

In 2004, I was nearly fifty years old, and an experienced doctor by the time, I joined another participation in a new Balint Group in the city of Aveiro, 60 Km on south of Porto. I travelled every month to Aveiro to present my cases, as well as to listen to the cases my colleagues brought forward. Ever since, I've participated regularly. Quickly I formed a group of three, and then four, and then five doctors going from our Health Center to the Balint group in Aveiro, 60 Km from Porto. It was a great effort, indeed.

And, quite often, despite my determination and diligence, I had the impression that nothing was changing into myself, I learnt nothing about magistral formula, or clinical normatives to apply

in my patients. But as the time went by, I realized that the clinical encounter presented to my eyes new aspects of our practice that I had never seen, linked to the patient, to our relationship and to myself. I could understand many aspects of my practice that were hidden from my eyes before. I was seeing my patients through other eyes that I didn't know that were my own eyes. I was regarding to my patients under other perspectives that I didn't know before. And, according to the metaphor of the Portuguese philosopher Mendonça, the windows of my eyes were opened not only to the patients, but also to myself¹. I began to understand Guite Guérin, when she wrote that our extreme difficulty as doctors was "to listen to anyone saying anything to anyone, and transform this anonymity of the author, the text and the addressee into a link between the patient and the doctor, so that from missed appointments and to successful meetings, and with a lot of time and patience, it could change: to hear someone tell you something about him, that represents or constitutes himself"².

I was changing my practice, my professional personality. I could hear from Karl Jaspers's idea of doctor: "great things come in the silence. Perhaps, the possible renewal of the idea of doctor has, nowadays, his privilege place in the general practitioner (...) His medical look has the sense of the situation. He has the solicitude for the naturalness of the man in his environment. He doesn't allow the patient examination to dissolve into a set of laboratory results, but he is able to assess, use and prioritize all of them. He allows the diagnostic methods to work within its limits, but he doesn't abdicate its judgement in favor of them. He knows the modern therapeutic measures, but he also knows how to distinguish them by categories of efficiency. It's peculiar to him, again, something of the Hippocratic attitude, which takes place in the course of life, and provides the relation of the patient with his illness. He acquires with the passage of time, that personal relationship with the patient in whose clarity it becomes easier to die"³.

Slowly and surely, it became clear to me that I was a better doctor, even though a little bit, it's true. But I felt that, I experienced it.

Only a few years later, when I became co-leader of my Balint Group, I had the opportunity to study the group dynamics and better understand what happened in that small group of individuals. The difficulties shown by the presenter, the attentive concern of the other members of the group, the attitude of the leader and of myself. And, in a parallel way, I could also imagine the difficulties of the patient telling his story, of the doctor (now presenter) that listens with the hope of understanding the whole clinical picture, the verbal and non-verbal symbolisms, and much of the misunderstanding and psychological tension in the relationship.

Now, fifteen years later, I can proudly say that, to this day, I never leave the group without learning new things and curiously with continuous expectations. To me, at times, when I enter the group, it's almost like entering through the door of the imaginary — "What extraordinary thing will happen today?"

Last spring, in the midst of a warm evening, I was resting on my garden bench, admiring the endless sky above me. I was alone, in total darkness. No sounds in the silent night. No

wind. Only a little bat crossing quickly the sky. Only the sweet perfume of the wisteria in my garden. I couldn't help thinking about the astronomers. How they spend many years admiring and studying the skies, memorizing the position of every planet and star, hoping that in an unexpected night, perhaps, something new will happen in that eternally unchanged sky. I could relate myself to that feeling, since I was also hoping for something, not knowing what, that one day, one unexpected day, would happen in the horizon of my practice, and could make of me a different doctor, a better one. I was feeling like the astronomer, that begins to believe that nothing is new in the sky, but slowly, insidiously, many things are happening within himself, many learnings are being incorporated in his wisdom, and he prepares himself to see changes that he couldn't detect before.

The elderly priest of my parish often says: "if a man finds something without looking for it, it may mean that he had sought it for a long time without finding it before". Just like me, in my Balint work.

Presently, looking at my journey after all these years, I recall the verses of Paul Valéry⁴:

<i>These days that seem vain, all vain,</i>	<i>Ces jours qui te semblent vides</i>
<i>For all the universe, all lost,</i>	<i>Et perdus pour l'univers</i>
<i>Have roots that with their might and main</i>	<i>Ont des racines avides</i>
<i>Labor through the sandy waste</i>	<i>Qui travaillent les déserts</i>

<i>Patience, patience be</i>	<i>Patience, patience,</i>
<i>In the blue vaults of the sky!</i>	<i>Patience dans l'azur!</i>
<i>In each mote of silence see</i>	<i>Chaque atome de silence</i>
<i>The chance of its own ripeness lie.</i>	<i>Est la chance d'un fruit mûr.</i>

So am I in my Balint groups, working in my deserts.

Thank you very much.

Be welcome to Porto.

Cheer to the 21st International Balint Congress.

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Cap. 02

Orationis Sapientia

Hearing Secret Harmonies: Balint and the Re-imagining of Medicine

Andrew Elder

FRCGP DEd (Hon)

*'Our great task is to succeed in becoming more human'
Jose Saramago (1922-2010) Nobel Laureate for Literature 1998*

I have been invited by the organisers of this our 21st International Balint Conference to give an opening talk on the subject of the conference. **Balint: seeing medicine through other eyes.** It is a title that takes us to the essence of Balint work. Indeed, the very origin of the Balint project lies in the 1950s with the Balints themselves bringing their 'other' eyes to help explore the work of family doctors. The general practitioners' task in those early groups – as it remains for all professionals joining a Balint group – was to let go of their accustomed way of thinking and begin slowly to integrate into their professional practice a deeper awareness of the emotions involved in the doctor-patient relationship: the practice of medicine and awareness of feelings *woven together* into the fabric of a professional relationship. Doctors emerge from medical school in a somewhat 'one-eyed' state, highly trained technically but with matters of the mind and their emotions rather pushed to one side. Our task is to re-connect to ourselves whilst also being able to practice medicine with all that that involves. In short, we must restore binocular vision!

When on the occasion of his seventieth birthday, Freud was greeted as the 'discoverer of the unconscious', he corrected the speaker and disclaimed the title. 'The poets and philosophers before me discovered the unconscious', he said. 'What I discovered was the scientific method by which the unconscious can be studied.' (Jones, E 1964)

In the same way we might point to the numerous descriptions of the doctor-patient relationship in the literature of the past and say that Michael and Enid Balint were the first to discover a method for the systematic observation and study of individual doctor-patient relationships.

We are heirs to a great tradition.

In his masterpiece *The Doctor, His Patient and the Illness* (Balint, M 1957) Balint expressed his challenge to doctors with characteristic and imaginative simplicity. What do we know of

the pharmacology of that most frequently prescribed drug: the drug 'doctor'? What are its indications? What are its undesirable and unwanted side-effects? These sentences ushered in what must be one of the most sustained ethnographic research projects in medicine. After *The Doctor, His Patient and the Illness*, four further research groups were convened during the ensuing years and all published accounts of their work (Balint, E & Norell, J 1973), (Elder, A & Samuel, O 1987), (Balint, E et al 1993) and (Salinsky, J & Sackin, P 2000). The last group focussed on doctors' defences and published its findings in 2000 'What are you feeling, doctor?' During the course of the research groups the questions became more refined but continued to look at shifts in the doctors' feelings when consulting with a patient. These were then followed up to evaluate consequent changes in the working relationship between doctor and patient, sometimes for as long as two years.

The approach adopted by the Balints - no teaching, no case notes, mutual exploration within a clear framework to facilitate free association and observation of shifts in feeling - was profoundly psychoanalytic. The aim was that elusive 'limited but considerable' change in personality - no mere addition to our professional armoury but a *change in the doctor*, leading to A New Kind of Doctor described by Michael Courtenay in the last paper he gave at an international conference (in Lisbon) in the following way..'perhaps we are at the dawn of a third phase of Balint work, one in which the doctor can access her emotions and consider the relationship at every consultation' (Courtenay, 2004).

In this talk I am going to look at *accessing our emotions through the role of the imagination in Balint work* and I am going to do so through the lens of poetry. But I hope there will be no doubt that my subject is Balint work! I am not advocating the study of poetry as a component of Balint work! But I do hope it augments my talk!

Poem: The Doctor

So, let me start by reading a poem. The poem is by Dannie Abse and is called simply 'The Doctor'. It is the first of three short poems, all by Dannie Abse, that I will read during my talk. Abse was a poet, playwright and novelist as well as a practicing chest physician in London. He was the youngest of three brothers, brought up in a Jewish family in Wales, and died in 2014. He said of himself, "I like to think I'm a Poet and Medicine my serious hobby." I've always loved his poetry and it is a pleasure to bring him with me to share with you in Porto.

The Doctor

*Guilty, he does not always like his patients.
But here, black fur raised, their yellow-eyed dog
mimics Cerberus, barks barks at the invisible,
so this man's politics, how he may crawl
to superiors, do not matter. A doctor must care
and the wife's on her knees in useless prayer,
the young daughter's like a waterfall.*

*Quiet, Cerberus! Soon enough you'll have a bone
or two. Now, coughing, the patient expects
the unjudged lie: 'Your symptoms are familiar
and benign' - someone to be cheerfully sure,
to transform tremblings, gigantic unease,
by naming like a pet some small disease
with a known aetiology, certain cure.*

*So the doctor will and yes he will prescribe
The usual dew from a banana leaf; poppies and
honey too; ten snowflakes or something whiter
from the bole of a tree; the clearest water
ever, melting ice from a mountain lake;
sunlight from waterfall's edge, rainbow smoke;
tears from eyelashes of the daughter.*

So, this our first case: what strikes you as you listen?

For me, the lines that really stand out are the two that describe the doctor's role, '*to transform tremblings, gigantic unease, by naming like a pet some small disease*'. But then I recall that strong first line; so direct that you want to hurry away from it. *Guilty, he does not always like his patients*. But however much he may dislike his patient the doctor must put his feelings to one side and care. At first sight, the poem seems to describe a specific scene, a house-call where the doctor is suddenly in the midst of a family crisis, but we also become aware that there is something universal, almost mythological about the scene as well. The dog barking in this household is reminiscent of Cerberus, the multi-headed dog of Greek mythology who guards the entrance to the Underworld - to stop people getting out! *Quiet, Cerberus! Soon enough you'll have a bone*. Perhaps we are present at a deathbed scene, or certainly a death-fearing scene: the wife's on her knees in useless prayer. The patient is fearful and seems to expect the unjudged lie from his doctor and certain cure. And then, as in all consultations, there is a prescription: '*so the doctor will prescribe and yes he will*' - and the poet (no doubt the doctor too) allows himself the relief of giving a wonderful flowing, timeless prescription of pure beauty and magic, reassurance - *the usual dew from a banana leaf, rainbow smoke* and then that telling, grief-laden, last line, with

what musicians call a dying cadence '*tears from eyelashes of the daughter*' – the eye and the mind, body and mind brought together.

The poem invites us to engage with a timeless role of the doctor to be present at the great transitions of life, a midwife to fearful uncertainty, a comforter and witness.

Put simply, to have passed this way before.

Oliver Sacks was surely right when he wrote, in his great masterpiece *Awakenings* (1973): 'There is, of course, an ordinary medicine, an everyday medicine, humdrum, prosaic, a medicine for stubbed toes, quinsies, bunions and boils (protocol-driven medicine perhaps?); but all of us entertain the idea of another sort of medicine of a wholly different kind: something deeper, older, extraordinary, almost sacred, which will restore our lost health and wholeness.'

Is the doctor willing to accept this role or not?

A Balint Group

If we're lucky, we are able to bring our uncertainties, *our* uneasiness, *our* uncomfortable feelings - even our wildly over-optimistic and reassuring prescriptions - to our colleagues in a Balint group! With the 'courage of our stupidity (Balint, M 1957)' we can begin to explore our feelings and mad ideas together within the discipline of a group. Michael Balint's use of the word 'stupidity' perfectly catches that *inner feeling* of risk which so often accompanies releasing an inner hunch, an image, or feeling into a more public place, the *attentive space* of a working group. But a word of caution; this isn't just a release of imaginative ideas for the sake of it, it is a disciplined exercise to begin to listen *to ourselves while we listen to others*, whether in the presence of a patient or whilst listening to colleagues in a group. Imagination is often thought to come mainly from within – the poet walking by herself in search of inspiration - but of course it arises as an inner response to the surrounding world of relationships and sensation.

The poet Robert Frost put it this way: 'a poem begins as a lump in the throat, a homesickness, or a lovesickness. It finds the thought and then the thought finds the words...' (Heaney, S 1980). Our imaginative response in a group travels upwards from a feeling and is then expressed as a thought. This is truly radical for doctors. Medical culture turned upside down. Our teaching was always to put aside any feelings and then to think.

In Balint groups we learn to listen to a case being presented in a rather similar way to the reading of a poem. In both we are invited to enter a half-lit world where we listen to feelings that lie behind the presenter's (or the poet's) words; to give our free-floating attention to thoughts that are only half expressed, to repeated phrases, rhythms, sudden unexpected moments, pauses or changes of direction; to words that seem symbolic or out of place; to mood and the language of the body. I say we enter a half-lit or easily overlooked world, because the area to

which we are giving attention lies between the rational, the accustomed and familiar on the one hand and the truly unconscious on the other. It is so hard to put our highly trained instinct to 'make professional sense' of what we hear into a neutral gear. In just the same way readers often want to 'make sense' of a poem, want to 'understand' it rather than to allow the poem's magic, its music and deeper meaning to work on them. Although a case has its origin in the reality of the consulting room, when it arrives in the group it is a product of the presenter's mind, divorced from time and place, and open for members of the group to respond through their imaginations.

Imagination

The Oxford English Dictionary defines imagination as 'that faculty of the mind by which we conceive of the absent as if it were present'.

The dictionary illustrates its definition with some lines from Shakespeare's *A Midsummer Night's Dream*, spoken by Theseus:

*And as imagination bodies forth
The forms of things unknown:
The poet's pen
Turns them to shapes, and gives to airy nothings
A local habitation and a name.*

In these few lines Shakespeare tells us that the poet turns his imagination, his airy nothings, into a 'thing' with structure and a rhythm of its own, a poem. If the collective imaginings of a Balint group (their airy nothings), are given shape, they take their form in a changed relationship between doctor and patient: the discussion *may change the angle from which doctor and patient see each other, turn things upside down or fill out the shadows in the doctor's mind*. In short, the doctor may be able to expand her range of movement in response to the patient, feel more sympathetic, more curious, and less disturbed by the strangeness of the patient.

In the first two lines Shakespeare reminds us that our imagination gives 'body' to things unknown, to airy nothings. But the words '*imagination bodies forth*' also suggest that imagination arises from the body, perhaps particularly from the physical world of the senses.

Every year, for a week in Italy a small group of us help to run a course on reflective practice and Balint for about eighteen doctors from different parts of the world. Two of us are GPs, one is a psychiatrist and one a psychotherapist. But the magic ingredient on the faculty is a poet (Daly, M 2019). On the Wednesday of the course the participants are guided through the various stages of writing a poem. After about three hours, much to their surprise and always to their delight, everyone has successfully written a poem and then agrees to read it to the others. Without fail this is a near-miraculous session. *But here's the point*. Our poet-tutor always begins the process by getting us to start from our senses; to get in touch with our bodily sensations of sight, smell,

hearing, touch, taste and movement – this is always the starting point for what later builds into a poem. And soon we find we've given *form to things unknown*. It is a wonderfully therapeutic and creative outlet for jaded and burnt out feelings. To find your inner poet!

Freud wrote that the ego was first and foremost a body ego (Freud, 1923). The Balints were certainly interested in bringing practitioners of the body (doctors) and practitioners of the mind (psychoanalysts) together (Balint, E 1975). Doctors touch and examine the body and listen to the language with which people talk about their bodies every day. They are highly trained to think about physiology, but must also *slowly learn to stitch this together* with a feeling for the symbolic language of the body; the significance of touch; and to pay attention to their own bodily feelings when with a patient or when listening to a case in a Balint group. Although not a doctor, Enid Balint was always interested in reports of the doctor's physical examination and what the group understood about this, believing that the physical examination of a patient, or its avoidance, carried considerable meaning for both patient and doctor.

Imaginative Perception

Enid Balint's key psychoanalytic concept was 'imaginative perception.' She described it as 'what happens when a patient creates his own *partly imagined, partly perceived world*' (Balint, E 1989). Thus, imaginative perception gives reality to the outside world, to the people to whom we relate, and to our own selves. In her view, at the earliest stages of life, the infant cannot perceive reality unless it is perceived mutually alongside someone else, most often the mother. Her thinking is close to Winnicott's often quoted idea that there 'is no such thing as a baby without a mother' (Winnicott, D 1964). They are an imaginative duo, linked, each creating the other through mirroring and playful interaction based on imaginative perception. Perhaps we can take this further and say that there is no such thing as a Patient without a Doctor. We co-create each other to a larger extent than we easily recognise. Echoes of early relationships come into the doctor-patient relationship all the time and are influenced strongly by the doctor's responses. My impossible patient will not be yours. And your favourite patient will not be mine!

In her essay *The Psychoanalyst and Medicine* (Balint, E 1975), Enid Balint writes that 'by setting physicians free to use and respect their own imaginations in a broader, yet still disciplined way, they can be helped... to tolerate what they see in their patients...particularly those aspects which may seem the most irrational and unacceptable, which once perceived, can show *each man's uniqueness*.'

The study of poetry sets much store by the author's unique 'voice'. Poets spend many years practicing their craft before they have found a voice that is theirs and none other. It is also our task as doctors to find our own authentic way of being a doctor. Like no other. The practice of medicine is highly complex. A doctor who is free enough to practice with the full use of themselves is more likely to find satisfaction and pleasure from their work. And benefit their patients too. In family medicine, no part of a patient has to be left behind at the door. Any starting

point is valid. The doctor must also be free to respond from a more personal perspective not only through the filter of a mainly medical viewpoint. The healing of the doctor and the healing of the patient go hand in hand. It is not just the 'inner poet' that must be found but the 'inner doctor' too!

It is widely accepted that practitioners need to develop more empathic relationships with their patients. And attachment theory makes it clear that the capacity 'to see oneself from the outside and others from the inside' (Holmes, 2010) is the key component of secure and creative relationships. Certainly both require the exercise of imagination. But how possible is this in the course of a busy schedule of clinical work? Just consider for a moment the number and variety of different people a doctor might see during the course of a single day, and the subtlety of their individual needs. With this in mind, I now want to take us back into the consulting room – not this time through a poem but through a brief clinical fragment from my own GP practice.

Nanny

My next patient this morning comes into my room. She's always jolly, always looking forward to things; she is a nanny, now in her seventies, and quite too good to be true. She was unable to buy, or even look at, a single newspaper during the Gulf War, the Afghan War, Any War. She gives reminiscences of her father, an engineer in the army, and how unbelievably good he was; all the furniture in her flat was handmade by him, and the dolls' house too. I think of her as an ageing single nanny still utterly in love with her father. She is looking forward so much to her sea trip around the Norwegian Fjords. She is full of good works and always brings magazines for the waiting room. How suited people are to their occupations sometimes. Or is this just how I see her? She is so much my idea of an old-fashioned nanny. I'm sure she knows every word of Winnie the Pooh and of every children's Nursery Rhyme. The sight of any suffering child upsets her dreadfully. She bustles in, asking for my advice, and says "Oh yes, how silly, why didn't I think of that?" "Of course, how right you are..." after more or less whatever I might have said.

Surprisingly though, on this occasion, this morning, after a few enquiries, a rash, a sore eye, she asks if tiredness could be her hormones.

Definitely a different note has been struck. All diagnosis is a musical problem. I don't say much. She tells me how very alone she has felt this winter, deprived of some of her activities through ageing, "It's not like me at all," she says, "to feel like this."

She tells me she feels so lonely and alone. And suddenly, I feel her life-long loneliness too. The realization of how she feels hits me with force. Our mood together changes in an instant. She slows down, and talks. I listen. Her only sister, Edith, may die soon. She has less energy to travel around, and is unable to visit her many 'children', her 'babies' as she calls them, and their children too. She remembers all their birthdays. One in midlife is divorcing and she is very

upset about the effect on the children whose nanny she was as well, although they are now grown up. She looks lost.

Gently I make a comment about the sadness of people parting. "There can be great sadness," I say, "when people you love are separating from each other."

She recalls the pain of her father's repeated absences from her home when she was a child herself.

Suddenly, the room is full of tears, stillness and time.

The whole emotional texture of our relationship has changed. We are now two people, no longer an all-knowing doctor and an always-obedient nanny.

I have a patient who has become more of a person and less of a caricature.

Tears Stillness and Time

The patient's childhood self and her ageing self are both in the room together. And in contrast to that lifetime length of time, our professional relationship has changed in only a fraction of time, no more than a moment really. When we speak of highly charged moments, we often say 'Time Stood Still'. And the room was certainly full of tears. My patient had broken down into tears and I felt inwardly tearful as I listened. I had also experienced a lot of separation as a child growing up and had somehow preferred to keep this patient at arm's length as some kind of cartoon nanny.

Professional work is made up of such moments, moments of occasional contact between the feeling worlds of two people. Sudden emotional access produces a change of gear. Nothing is true for long, if ever, and must be freshly re-imagined. When we think we have arrived somewhere, the patient has usually moved on!

It is so often said that GPs have no time. As professionals we are often left feeling that we have too little time as we rush from patient to patient, or from meeting to meeting. But time adds up. Family doctors spend more time with their patients than is often realised.

Time is of the essence when we consult. 'I won't keep you a minute, doctor'. 'I seem to be taking so much of your time these days, doctor'. 'Don't worry, take your time'. With an open-minded unhurried attitude the important point is reached more quickly, time expands; whilst hurrying, anxiously pressing in on the patient, time contracts. The clinic over-runs. *Past trauma continues to seem like yesterday and deep down, in the unconscious, there is no measure of time at all.* And hovering over all our efforts, only just out of sight, just off-stage, is the time limit of 'all our little lives' (Shakespeare, W 1962). The sound of Cerberus barking can be heard again.

In his recent book, *The Order of Time*, the Italian physicist, Carlo Rovelli, writes '*We are time. We are this space, this clearing opened by the trace of memory inside the connections between our neurons. We are memory. We are nostalgia. We are longing for a future that will not come.*' (Rovelli, C 2018)

Everything is always present. Time can suddenly expand or collapse in the consulting room as it also can in the course of a group discussion.

'Every moment is a window on all time.' (Wolfe, T 1952)

We speak of holistic or whole-patient medicine. Sometimes this can sound not much more than a curricular requirement to include a psychological and social context for the patient, but it can also refer to a *sudden snapshot*, a glimpse of a more complete person suddenly perceived. What Balint called '*the totality of the person, a human being with his own goals and failures, his joys and sorrows...*' (Balint, M 1966). These pictures leave an after-glow, a lasting impression until another moment updates them. Just as it was for my patient and myself, they serve as navigation points, for doctor and patient alike.

In my next poem, the poet gives us just such an imaginative glimpse of himself as a doctor and as a person.

The poem is called:

X-Ray

*Some prowl sea-beds, some hurtle to a star
and, mother, some obsessed turn over every stone
or open graves to let that starlight in.
There are men who would open anything.*

*Harvey, the circulation of the blood,
And Freud, the circulation of our dreams,
prided honourably and honoured are
like all explorers. Men who'd open men.*

*And those others, mother, with diseases
like great streets named after them: Addison,
Parkinson, Hodgkin – physicians who'd arrive
fast and first on any sour death-bed scene.*

*I am their slow-coach colleague, half afraid,
incurious. As a boy it was so: you know how
My small hand never teased to pieces
an alarm clock or flensed a perished mouse.*

*And this larger hand's the same. It stretches now
out from a white sleeve to hold up, mother,
your X-ray to the glowing screen. My eyes look
but don't want to; I still don't want to know.*

In this poem Dannie Abse brings his boyhood self alongside a moment in his adult life as he prepares to look at his mother's X-ray on the screen. The poem draws its tension from the poignancy of a particular moment which is both professional and highly personal. The poem is a meditation on the nature of the medical gaze, of medical 'looking'...'*my eyes look, but don't want to...*' and it is a reflection on what the poet feels about himself as a doctor. It takes the form of an inner dialogue with his mother. He contrasts himself, a *slow-coach colleague, half afraid, incurious*, with his medical forbears honoured for their discoveries, '*men who'd open men.*' Freud and Harvey are brought together in a single sentence. The reader is left with the author's anxiety of whatever the X-ray will reveal, but also something of the burden of what it means to be a doctor.

It ends: 'I still don't want to know.'

How natural not to want to know! Surely, it is healthy to have a limited appetite for pain and suffering? Emotional support is needed in finding a balance between what we can face and what we can't. Although we have to find that balance for ourselves, the surrounding professional and social culture has a considerable influence. A perfectionist and heroic culture with an unforgiving and critical underbelly can make it very hard to admit vulnerability. A Balint group, on the other hand, can provide a culture of support through fostering individual respect and the development of trust but can also help in recognising what is possible and what is not. Where would we place ourselves on the Dannie Abse self-rating scale between heroic over confidence '*first on any sour death-bed scene*' and his *self-description, 'incurious, half-afraid?'* And whatever our individual disposition may be, our 'not wanting to know' will change from patient to patient, illness to illness, year by year and with whatever personal ups and downs we are facing at the time.

Patients are so often mirrors to our selves.

The exercise of imagination takes energy. To come face to face with a difficult or painful situation requires courage. Outward energy is more available to clinicians if they are feeling secure within themselves and within their professional setting. The burden that most clinicians carry is very great. Feelings cross the desk in next to no time at all. Anxiety and depression, paranoia and anger are all more infectious than a virus. And not only feelings; whole thoughts

can move from person to person, embodied pain, unconscious communications; all, in an instant, can appear in the doctor's mind.

A Balint Case

One of the doctors in our group presented a recent contact with a patient he had known for thirty years. He told the group that he had felt profoundly depressed after seeing her. '*It just sat on me all day*', he said.

Mary, a woman in her mid-fifties had been recently widowed. Her husband had died suddenly in the street while they were out shopping together. Mary had always seen the doctor every few weeks; her husband only rarely. She had a jokey and self-deprecating relationship with her doctor who told us in the group that he felt very warmly towards her. 'She's a northerner', he said 'with a deep voice, a dry sense of humour, sharp, and amusingly dismissive of men. She had been the first female out of 43 pregnancies in her family!' And she always brought a present back for the doctor from her holidays. The doctor, a highly experienced Balint practitioner, had worked closely with her at times of earlier distress. He mentioned that there had been virtually no sexual life in the marriage after the birth of their only child, a daughter, and that he had always felt that she and her husband were not particularly close.

The doctor had already seen her twice since her husband's death, but on this occasion, Mary arrived bearing her husband's death certificate. She had seen his body after the post-mortem. 'It was awful', she said, 'they had cut his head open, it was an absolute mess.' She was extremely distressed, no longer concealing her feelings, and the doctor was profoundly affected by her grief. He had suddenly felt that he had '*never known her and had completely misjudged the depth of her emotional life.*'

It was this feeling that he brought to the group.

There were many different voices in the group discussion. Not a poem but a symphony. There were long silences as her shock and grief entered the group. Had the doctor suddenly caught Mary's transmitted shock at seeing her husband's mutilated head? Or was her shock a sudden realisation of their damaged relationship? Something similar to what the doctor was later to feel: 'I never really knew him.' Did the doctor feel guilt? He had not been able to save her the ordeal by issuing a death certificate. Was this a new Mary? Or simply one the doctor had never known? Or that she had never allowed him to know? Had she always loved her husband, despite the difficulties in their marriage, much more deeply than the doctor had ever realised?

The leader commented that the doctor was surprised to find how deeply he felt for this woman.

At our next group meeting, two weeks later, the doctor told us he had arrived with no clear

plan when he saw the patient again. He felt open-minded, *without defences*. He told us 'when Mary had sat down...and I asked 'how's things?'... 'she seemed to go back to her old sort of jolly, oh not so bad...her matter of fact way of being'. After a few of these exchanges, the doctor referred back to their last meeting.

'You know, Mary, I've known you for thirty years, and I felt as though I've never known you at all.'

The tears roll down her cheeks. The doctor sits with her. The tears are for herself, her husband, and perhaps for the years of banter which has prevented her from knowing and being known, and which she has used to hide her emotional needs. 'All my life I've had to look after other people', she says. 'And now I want to be looked after myself.' There is no hint of jokiness. Mary makes a clear statement about her needs. It comes after the doctor's utterly unambiguous statement of his own feelings which reach into the heart of their relationship.

With this deeply human moment in a real consultation we are a long way from the mythic encounter we heard in the poem at the beginning of my talk. Through the work of a Balint group, a doctor who has known his patient for over thirty years, is able to summon the courage of his imagination and in a single consultation transform their relationship together. It is a moment in which doctor and patient face a painful truth: face to face.

Re-Imagining Medicine

If the realities of two-person medicine are taken seriously and the Balint approach sufficiently accepted, it would lead to a re-imagining of medicine itself. Through their discovery of perspective, the great masters of the Italian renaissance moved us away from a flat two-dimensional view of the world. A comparable task for the practice of medicine still lies ahead of us. The challenge is well described by Ian McWhinney, sometimes referred to as 'Canada's Founding Father of Family Medicine', in the lecture he gave in Oxford at the international Balint conference (IBF) conference in 1998.

'The implications of Balint's ideas for medical education have not yet been addressed. We speak of adding skills and competencies, but not of teaching a *new way of being a physician*. The difference between these two is fundamental: one is additive, the other transformative; one assumes the status quo is adequate but incomplete, the other that the status quo is *fundamentally flawed*; one sees the solution in terms of additional tasks, the other *in terms of a transformation that will affect everything the physician does*' (McWhinney, 1998).

Once we have learned to listen more deeply, our clinical responsibility must be to attend to the emotions in every case. We can no longer live with what earlier I called one-eyed medicine. Balint is a call for radical change in the culture of medicine; to become fully self-reflective, and to become a culture in which doctors take their own emotional and spiritual development seriously and in which medicine becomes a moral as well as a technical education.

What of the Future?

So, what of the future? Just as a consultation is a moment in a much longer story, so also is our conference. Time is on our side. A great future for Balint work still lies ahead. We must have the courage of our imagination. Once the future is imagined it can be lived.

In recent years the focus of our research efforts has mainly been on establishing the effectiveness of Balint work through the use of measurable outcomes such as psychological mindedness, reduced rates of burnout, increased role satisfaction and enhanced professional self-esteem. But we must not neglect our own history of group-based narrative research. In the past, much of this work has been undertaken by GPs, but accounts are beginning to appear describing how a Balint initiative brought about change in an Intensive Care unit or an Oncology department.

Unexplored areas of potential cross-fertilisation with neighbouring disciplines lie at our doorstep. There is a rapidly growing and sophisticated body of knowledge about how attachment relationships, which are strongly echoed in all carer-client relationships, affect many aspects of human development, patterns of mental illness, the language of care-seeking, symptoms and the outcomes of treatment. Advances in attachment-based research, neuroscience and relational aspects of psychoanalysis are influencing each other rapidly at present. All have the potential to furnish us with convincing evidence for the validity of RBM – relationship based medicine! But at present these disciplines are relatively unknown within the field of medicine. Perhaps this is a subject to be pursued at a future Balint Research Congress?

Here is Peter Medawar, a distinguished scientist, writing about the role of the imagination in scientific method: *Every discovery, every enlargement of understanding, begins as an imaginative preconception of what the truth might be - a hunch or hypothesis arises by a process as easy or as difficult to understand as any other creative act of mind; it is a brainwave, an inspired guess, a product of a blaze of insight. It comes anyway from within (Medawar 1975).*

The case of Mary and her doctor, which I described earlier, was taken from the last of our research groups with Enid Balint, the so-called 'surprises' group (Balint, E 1993). In the research aspect of that group, we focussed on our capacity to be surprised when we are consulting with patients. *Why are we not surprised more often?* Do we habitually screen out discordant observations in order to comfort ourselves with the illusion that we 'know' our patients? We realised that unless we can be surprised by our own responses as well as those of our patients we cannot deepen our understanding. *Surprises result from the capacity to register unexpected observations.* Contemporary research in neuroscience is now employing a similar concept of 'surprises' in its descriptive models of how the brain functions. We are far from having completed our response to Balint's original challenge about investigating the pharmacology of the drug doctor.

Sadly, in our present culture Balint work is likely to remain peripheral; often pursued with passion and conviction but a minority pursuit, poised in a fragile position in health care

organisations and hospitals, always needing to fight for its space. What was at first an airy nothing, imagined by the Balints in the 1950s, now has a clear structure and form: an international federation with twenty three different national societies across many different cultures. Currently there are Balint projects under way in Greece and Iran. In addition to groups on training schemes – for GPs, for psychiatrists, for psychosomatic specialists and for junior hospital doctors – multi-disciplinary groups are now increasingly being established in departments working with high levels of anxiety and emotional impact – A&E, intensive care, oncology, palliative care and in-patient psychiatry units. In a highly pressurised environment 'good-enough' Balint groups provide a much-needed space for doctors to think and feel. Groups within healthcare settings can go a long way towards establishing a healthier organisational culture – one in which the emotional needs of professional staff are recognised so that in turn they are more able to respond to the emotional needs of their patients. At a recent international congress a presentation was given entitled: Bringing the World Together through Balint: creating a virtual Balint group for doctors around the world (Hoedebecke, K 2015). This paper gave a live demonstration of the work of a group of young doctors from different countries (indeed different continents) who meet regularly in an internet-based Balint group. And in both the USA and in Australia, internet-connected groups are becoming increasingly common. In a few days time we shall hear the winning essays written by medical students from all over the world who enter for the Ascona Student Essay Prize – always a high point in any international conference. Balint groups for medical students during their training are on the increase. And in Scotland now, all graduating medical students are given a slim pocket-sized volume of poems, many of them written by doctors and students, called Tools of the Trade, to carry with them into their new career (Morrison, L 2018). Perhaps there will be a growing impact from all these various sources of Balint reflection that will slowly affect the mainstream culture. Or perhaps their appearance is an early sign that a cultural shift is already underway.

Through Balint participation, doctors slowly learn to register feelings, images, sudden hunches; and to observe something of the doctor-patient relationship as well: to listen a little and to ask a little, while also doing whatever needs to be done; breathe in, breathe out, Body and Mind; the two together, hand in hand.

I have tried to weave some strands together – poems, moments from the consulting room and reflections on Balint work – in the hope of stimulating us to think more about the role of the imagination in our clinical practice.

Our task is no less than the re-imagining of medicine itself.

I began with a poem. I will finish with a poem.

It is the last poem in Danny Abse's volume of Collected Poems:

White Coat, Purple Coat.

Song for Pythagoras

*White coat and purple coat
a sleeve from both he sews.
That white is always stained with blood,
That purple by the rose.*

*And phantom rose and blood most real
compose a hybrid style;
white coat and purple coat
few men can reconcile*

*White coat and purple coat
can each be worn in turn
but in the white a man will freeze
and in the purple burn.*

Thank you

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Cap. 03

The theory and structure of Balint Groups

Seeing Future of Medicine Through Other Eyes

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Abstract

Even if we do give a lot of energy to integrate scientific knowledge about illness and their treatments and even if it soaks up most of our professional time right now, robots will soon do better than us, and this is no science fiction.

The material of life is woven of multiple threads which include: links, suffering and finitude. There will be no standard relationship software to repair this material.

In this paper, I argue the importance of Balint groups for the future of human medical care by using three concepts: landscape, suffering and constellation.

I will try to demonstrate how the Balint experience can enhance the doctor's capacity to see the patient's suffering with human eyes.

Seeing Future of Medicine Through Other Eyes

The art of medical care is the art of living and practicing our values the best way we can.

These values assume that life is sacred, that health is our target and that care is the only reply to suffering. They seem obvious to me and probably for you, I imagine. But everybody doesn't share this point of view, oddly enough even care givers!

For instance, some people think medicine should be only a science.

Even if we do give a lot of energy to integrate scientific knowledge about illness and their treatments and even if it soaks up most of our professional time, robots will soon do better than us, and this is no science fiction. Radiologists already know about it: artificial intelligence makes less mistakes than they do.

In a way, it isn't a scandal. It will take a lot of time to change our perspective. Artificial thinking will be inescapable and necessary to tackle illnesses and their treatments but the art of building relationship with the patient and the way of watching him through his illness will take a main position in our practice and that could be a good thing.

We will have to focus on "the doctor, his patient and the illness".

Beyond objective symptoms that can be treated from a checklist in a database, the patient presents us with a real landscape, while coming into our consulting room.

"Landscape" is the first concept I want to focus on. I have borrowed it from the French psychiatrist Jean Oury whose work deserves to be known.

In short: "landscape here means the global view you get without thinking about it" that is what Jacques Lacan, a better-known French psychiatrist calls "l'instant de voir"², which could be translated as "the moment to see".

We find this global view beautiful or sad. Or there may be a detail that catches our eye and makes us feel uncomfortable, but we can't identify it. This first instantaneous stage is directly linked to what we can call **the presence**. Indeed, to be sensitive to the landscape we need to stop and be present to the person who is presenting himself or herself to us as Jean Oury says.

In his description of the landscape, he refers to Edgard Allan Poe's short story: "the Purloined Letter" where the policemen don't see the stolen letter because it's too obvious, because the current investigation field doesn't match the searcher's logic but matches the robber's logic. The Policemen follow their own logic: a thief should hide what he robbed, but here the thief was different.

The question is well about "the other" and everything that goes with "the other". Let's keep this in mind.

We sometimes can't say anything else than a "wow" in front of a landscape, it may be enough.

This reminds me of a fifty-year-old female patient, she looked neat without make-up, a bit tired, she looked at me and asked for a check-up. She told me her husband didn't want her to get treated because he said she was fine, and she was worrying about nothing. At that moment, I saw a sad and helpless landscape and I just expressed my surprise: "really?".

Then I let her have a check-up which appeared to be reassuring. Ten years later, she came back to me, her husband was dead, and she reminded me of that day when I said: "really?" to her. I had forgotten of course. From then on, we shared many things about health, the need to be loved, prevention, the importance of trust which her husband didn't have. We also talked about her need to meet up with her family who she had not been allowed to see for years. We also

thought about how difficult it is to get rid of somebody's influence.

Of course, all this was already there when we met for the first time, when I just said "really?". This moment is, for me what Balint called a "flash", i.e. this little thing in the immensity of a meeting that echoes with the patient's suffering and informs her that I assessed the landscape.

*"Landscape is something we must cultivate, said Oury; it is an introspective work, a preparation of world apperception"*³. Apperception means, in the same time, the way we apprehend our perception of the object we see and the act of being conscious of ourselves. Oury continues with this: *"it belongs to a certain way of being in everyday life"*

This is interesting and I believe that we can prepare and grow our internal skills to acquire competence in this area and it is an everyday lifestyle. This is what Balint groups taught me from the beginning. Everyone who participate in Balint groups knows well that some change of view occurs in our medical practice.

Our priority is rather taking care of complex situations more than simply diagnosis and treatment.

In this hyper connected world, more human complexity will ensue. One important question that arises from this hyper connection is what is public and what should be kept private in this optic flow of highly valued social networks? What are we supposed to do with the obvious increasing loneliness of persons who feel isolated in real life even if they have thousands of virtual friends?

What about the virtual world: although immersion in virtual reality headsets is an extraordinary learning tool, it may increase the number of people disconnected from reality.

We can foresee multiply examples of the difficulties we will have to cope with in the future. I am thinking about the excellent presentation of Dr. Salinsky⁴ in Metz in 2015 where he questioned with his known eloquence the difficulty the patient encounters when he sees a different doctor each time he needs to see one and where his computerized medical file seems more important than he is.

There will be more need in the future for caregivers able to connect with the patient and to be able to resist to the temptation of using simplistic uniformed standard products and medicalization.

It is also a landscape which is presented to the group by a participant when he is talking about a case. Like painters, the teammates will express their different perspectives according to their points of view. If there are opposite or conflicting points of view, they will improve contrasts in the landscape. This will open a richer and distinct view of the case. Thanks to this, we learn to become aware of our inner state in front of the view given to us. It isn't the painting itself which

is changing, suddenly we understand better what moved or worried us when we first looked at it. A part of the scenery that we couldn't see at first, is now appearing like Alan Poe's "purloined letter".

This change of point of view can bring some life back to the relationship but also brings a new form of existence and knowledge of the ill person.

I'm referring to Winnicott's statement:

"Not being seen by the mother, ... means not existing. ... the child cannot take the risk of looking at his mother if watching her draws a blank page; he needs to get something from her about himself." ⁵

This is quite a complicated equation. To make sure the patient can exist, the caregiver should look at him and see something about him or her. This means that if we see something in the patient's landscape that matches what he or she is, the patient can feel his or her own existence. Or the opposite, if the patient encounters emptiness or indifference from the caregiver he can't even risk to show anything about himself or herself because he or she will fall into an abyss of non-existence. Here the caregiver's loss their humanity.

If we are able to open ourselves and become conscious of the patient's condition, it will change his point of view about himself or herself.

"We", here, refers to the medical staff, the politicians and the entire social world altogether. That's the real problem: what about the patient if the doctor is a robot? if the caregivers are only paid to do paperwork? Again, what about the patient if 'taking care' is not paid or just not valued? if the patient's treatment is only refunded if a pathology is recognized?

For instance, we see in Belgium on one hand a total free care in diabetes and on the other hand all kinds of associations who struggles to recognize their rare disease or illness. These patients need an official recognition of their suffering to be treated!

This is a global phenomenon in all "developed" countries.

That's why, after landscape, I want to highlight another word: **suffering**.

Because, what is at stake when we are ill is the suffering it generates. Nothing is more difficult than being present at someone else's suffering, at his failure or at his basic fault. The meeting with other's pain is always highly traumatic.

Wilfried Bion⁶ even said in his latest letters in 1979 that there is a kind of danger in every encounter: *"When two personalities meet, an emotional storm is created. If they make sufficient contact to be aware of the other, ... the resulting disturbance is hardly likely to be regarded as necessarily an improvement on the state of affairs had they never met at all. But since they have*

met, and since emotional storm has occurred, the two parties of this storm may decide to make the best of a bad job."

That's the challenge: to make the best of it.

An honest meeting crests chaos, disturbance and intense emotions, which are difficult to bear.

Cultivating the meeting with the other is neither easy nor obvious, especially when the other is suffering.

How do we make sense of this very challenging attempt to make a bridge to the suffering patient?

Paul Ricoeur⁷ says: "when we encounter a patient who has pain, we realize that he suffers from something more than only the pain due to his illness". He tells that the suffering seems to throw the one who suffers into a crisis where he is separated from everybody.

Pain separates, and according to Paul Ricoeur, there are four levels of separation:

The lowest level, is when one lives his experience as unique, he is isolated, and nobody can understand or experience what he lives, he feels himself different than any other: **it is unique**.

In the next level, the vivid experience is uncommunicable, the other can't understand nor help; between the sufferer and the other, the barrier is unpassable: it is **the loneliness of suffering**.

On a more strident level, the other can appear as an enemy, the one who makes me suffer: it is **the injury of suffering**.

Finally, in the highest level of virulence, the illness can be lived as a malediction we were born to. So, come the questions: why me? why my child? it is **the hell of suffering**.

Indeed, in the quest to join our patient, something coming from the centre of his heart separates us: his incapacity to tell, his incapacity to do, his incapacity to face his illness. How to remain present to him?

The art will consist in overcoming what is unattainable, what is not immediately accessible by our understanding, what is cloudy in the other.

Respecting others means that we must accept that something that is present will and never be reachable. The part which makes him unique and cloudy can't be transferred. With his presence, the other changes something in our own landscape which as caregivers, is already a lot to take into account.

We let ourselves be shaken, this means that we stay present with our own primitive suffering. This level of suffering, which we are not immediately aware of, evoked at the first time we were confronted with the other; the early experience of rage about something irreplaceable, impassable; the injury of hate and the Hell of loneliness. This is an archaic suffering but later there will be the awareness of our own existence and the suffering of our finitude. We must necessarily feel all these emotions to get in touch with our patient, to create paths and bridges between two human continents. Not to understand in order for the other to become the same but in order to be present at the immensity of his loneliness and the awareness of human diversity. Maybe, I said all this to say only what follows: if robots want to be better than us, they will have to touch suffering ... and that is not for right now.

Nevertheless, the main question is what to do with our suffering?

The social and political world is changing. More burn-outs, less real values to defend like professional secrets, tenderness, solicitude, support. In the future, we will have to cope more with multidisciplinary encounters around a patient; more intrusion of institutional support for the patient. How are we going to manage the task to let the purloined letter emerge in the patient's landscape? What will the singular dialogue with the doctor become? What will happen with the private and public boundaries? All these are questions we could explore. I am really convinced that small democratic equal groups are the future of humankind to support our human fragility and to answer some of these questions. I hope this as a human being. And of course, we will have to defend with enthusiasm our Balint groups in which the human values I described in the beginning can be worked out.

In Balint groups, we can find the beginning of an enlightenment and relief through support and buffering in every traumatic meeting as Bion described.

In conclusion, I want to raise a last word: **constellation**.

The material of life is woven of multiple threads which include: links, suffering and finitude. There will be no standard relationship software to repair this material. There will only be an appropriate reaction to a particular patient in a singular tense landscape by a caregiver or a care team.

The future of medicine depends on a good and constructive relationship between all members of the care team.

Following these ideas, Balint group's future is secure because people will need our help. However, it will not be easy to defend our values because they can't be scientifically proved nowadays, they are only human, fragile and weak. Indeed, Balint groups form, together with the members, the leaders and the setting, a constellation around the patient's problem. A constellation is a set of singular stars whose interdependence rest on the tiniest force of the four physical forces of nature: the attraction one.

In Balint groups, we work on this tiny force to understand the suffering of our daily human landscape.

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Balint's Essential Creativity

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Abstract

Balint was a maverick in the psychoanalytic movement of the mid-twentieth century. The genius of his contribution is evident in the underlying values and practices of current-day Balint groups. Revisiting his oeuvre illuminates the background behind subtle choices in conducting a Balint group. First, his emphatic valuing of direct observation led him to recognize relationship as crucial to the healing process. Secondly, within relationship, words aren't necessarily the primary currency - atmosphere is also a matrix of connection and healing. And finally, his model of development explains the necessity for a space free from impingement by external pressures in order for creative action to arise. We offer a selective overview of Balint's psychoanalytic contribution and show how his seminal thinking in psychoanalytic practice is relevant to his group work with the hope of deepening appreciation for the nature of Balint group.

Balint's Essential Creativity

Balint was a significant figure in the development of psychoanalysis in the mid-twentieth century. He not only helped to develop psychoanalytic theory and practice, he, more than many psychoanalysts of his time, wanted to extend what psychoanalysis has to offer into wider usage. Balint groups in medical settings are one of the most significant ways his genius has an ongoing life. But few people who lead Balint groups, and even fewer who attend have any idea about the underlying psychoanalytic principles of a Balint group, let alone the specific values that Balint himself brought to psychoanalysis. In revisiting some of his writing we discovered ways his ideas illuminate the reasoning behind a number of choices in our stance conducting Balint groups. For this presentation, we have selected a few elements of his *psychoanalytic* thinking and we want to show how they contribute to our understanding of what he developed in group work with doctors.

The first thing of note in looking at his legacy is that Balint was an excellent writer. He wrote penetrating clinical descriptions based on keen observation. This led him to examine circumstances where traditional psychoanalytic technique didn't yield results. Balint was a pioneer. Rather than defend traditional concepts and try to make treatment fit a model, he focused fiercely on the unknowns of the human moment. So we're talking about both openness to observe even when what is being seen doesn't fall into familiar frameworks and then working with these observations to formulate and articulate them for further consideration. And in Balint's case, he was particularly interested in what goes on in a relationship between two people, the ways one person exerts influence and impact on another.

In his forward to Balint's most significant book, *The Basic Fault*, Ornstein, reported that Balint "abhor[red] speculations about 'dynamics' and 'genetics of the patient's psychopathology, especially when [this] was based on the [patient's] history ... He focused on 'how patient treated doctor' and on 'how doctor treated patient' as entry points to understanding and characterizing the nature of each unique therapeutic endeavor." (Balint, 1992, p. viii)

Balint was interested in countertransference in the days when that concept was just beginning to become an accepted area of investigation. Seeing ways the analyst unconsciously contributed to clinical impasse during certain passages of analysis helped him formulate a developmental model which provides guidance for making clinical choices. Please bear with us as we offer a very brief version of this model - which we will later link to elements of the Balint group process.

Balint identified three distinct states of being arising out of infantile development that are organized completely differently from one another. Psychoanalysis of his time was based on understanding the dynamics of the oedipal configuration: a triangle of object relations. This is his third level, an area of mind where verbal language is meaningful and problems arise out of conflict.

Balint was among a small number of psychoanalysts who developed clinical technique for cases where the patient is not organized at this level of experience. These were typically failed psychoanalytic cases. They involved mental experience at a second level which he described as involving only one other person in addition to the subject or a first level where there is no external object.

At the first level, Balint countered Freud's idea that the infant begins in a state of primary narcissism. Instead he saw the infant still linked to fetal experience of being in a "harmonious interpenetrating mixup" (Balint, 1992, p. 66) with the environment, a stage he called primary love. Writing about the difficulty in describing this object-less state, where the individual also is not alone, he proposed the language "pre-objects" to name that which isn't yet distinguishable. Our understanding is that this is the sensibility permeating what he called the "area of creation" where "[t]he subject is on his own and his main concern is to produce something out of himself..." (Balint, 1992, p. 24) Balint couldn't say much more about this phase because the contents of

this stage don't signal to itself or to us anything about what's going on. Things just go on. So we can only intuit that creativity is somehow active because from this state a self emerges with the possibility of recognizing and relating to others.

Balint was particularly interested in the second level, the area of the subject and one other. When things go wrong during passage into and through this stage, the subject is left to feel "at fault" or "broken," which is why he called this the basic fault level. Problems are not about conflict in the psychoanalytic meaning of that word which involves the self, another and a third. Instead, it's a state of being broken. Distinguishing therapeutic action at this level, Balint said that help involves patients' developing something new. There is much to be said beyond the scope of this paper about psychoanalytic technique with patients suffering at this level but a little information is relevant to our effort. At the level of basic fault verbal interpretations and explanations are either useless or counterproductive. The patient is likely to misconstrue the meaning of words and experience the relationship as adversarial. A psychoanalyst can become quite confused and frustrated when encountering this kind of reaction. Medical doctors, too, run into great difficulty with such encounters. Typical "doctoring" doesn't seem to work and something different is needed. At the level of basic fault, the other is relevant to the subject only so far as they provide or deny the subject's needs and desires. The other's subjectivity has little meaning. In this situation, the atmosphere and musicality of the practitioner's presence are more useful than explanations.

Balint viewed impasse in treatment at this level not as the patient resisting but rather as the patient needing to develop. This formulation helps analysts access empathy for such patients as being without the psychic apparatus to navigate overwhelming circumstances. Balint noted, for example, that a patient's silence may be resistance and/or fleeing from contact, but it also may be fleeing toward something creative in the sense of the first level of his model where the patient needs to make something from himself, not be taught or become compliant with the other. (Balint, 1992, p. 26)

We will draw on this selective overview of Balint's many contributions to psychoanalysis to show their connection to his group work. First, his emphatic valuing of direct observation led him to recognize relationship as crucial to the healing process. Secondly, within relationship, words aren't necessarily the primary currency - atmosphere is also a matrix of connection and healing. And finally, his model of development explains the necessity for a space free from impingement by external pressures in order for creative action to arise.

Our first point is Balint's insistence on observation and his skepticism of preformed technique. The purpose of a Balint group is to allow what has been unconscious to emerge into awareness in a process that supports the doctor to make use of that new information. This can never occur through manualized methods. The most potent tools we bring to Balint group work are our observation and open minded reflection. Listening to how a case is presented, in other words, keen observing, can offer invaluable information about ways the doctor may be carrying something that belongs to the patient. For example, the doctor who expresses a great deal

of concern and sadness while describing a patient who is nonchalant about his situation may presume that her caring is simply part of her duty as a doctor, not realizing (until the Balint group helps unpack the experience) that this patient is actually afraid to know his future, leaving the doctor to experience the patient's un-think-about-able grief.

Given the primacy of the relationship between doctor and patient, and the complexity of how we humans impact one another unconsciously, the observation of experience rather than explanation or teaching provides rich ground for creative process. Giving an example is both easy, because it's evident in all Balint groups, and difficult, because it's stuff that isn't easily captured in words. Even so, the following example shows vividly how meaningful the presented doctor/patient relationship is, even with significant constraints of both time and role. It also shows how a Balint group's keen observing helped the doctor appreciate the value of her presence in the patient's life.

A third year resident in primary care presented a refugee whom she had just seen for the second and probably last time. He was very ill at his first visit and could barely walk. She ordered tests and arranged to see him again as soon as possible. Just before the second visit she received test results confirming a deadly diagnosis of an advanced disease. The patient arrived, now wheelchair bound. Knowing little medically about his condition she knew she had to give him the hard news and prepare him for the vast medical system that would watch over his care and dying.

He haunted her. She knew she might never see him again and was not sure they had established a connection that would help him feel cared for. She demonstrated to her Balint group how, with the wheelchair in the cramped consulting room, she had ended up kneeling on the floor in the hallway so that they could see each other.

The group work centered on this physical situation and associations to it: the doctor and the patient were cramped for time as well as space; they needed to face something together and it was very hard to face; the doctor wanted to see him, to make a connection, because she knew technical medicine would be useless in his case.

The group work helped the presenter, and at a later session she reported having been able to visit her patient in the hospital in his last week of life. She approached him gently and said, "I don't know if you know who I am?" And he answered with grateful warmth, "Oh, yes, I know. You are my doctor."

Balint famously did not want to make primary care physicians into psychiatrists. He didn't think there was something missing from the doctor/patient relationship. He actually thought the relationship itself was under-appreciated. This case exemplifies the uniqueness of each doctor/patient relationship and shows how close observation was key to helping the doctor understand the emotional meaning of the case. "At the center of medicine there is always a human relationship between a patient and a doctor." (Balint, 1957)

On to our second point: Balint helped psychoanalysts understand ways that healing occurs beyond the use of language, where explanations have limited effect. Balint's idea about an initial objectless stage of development, the area of creation, is useful when considering the Balint group and its effectiveness. Despite structure which limits the activity and interactions among members, Balint groups paradoxically sponsor a space for wildly unlimited creative association. What the presenter is doing during push-back and what group members are doing as they work on the case may have to do with Balint's first stage of development. Both may be engaged in a kind of imaginative work that doesn't primarily draw from the level of language. A mature Balint group allows a kind of spaciousness with the quality of a "tranquil quiet sense of well-being," (Oppenheim-Gluckman, 2015, p24,) along the lines of Balint's first stage. This may be especially helpful in cases when the patient brings early needs to the practitioner-patient relationship.

The following case contained this kind of experience:

A psychologist presented a man she had seen in therapy for many years with an African-American father and Scandinavian mother. The patient's depression had deteriorated. His therapist was haunted by an early consultant's prediction that the patient would commit suicide and by the patient's recent remark that he would be in treatment with her for the rest of his life. The Balint group, a mix of senior clinicians, was unusually silent at the beginning and repeatedly throughout the group. When attention was eventually drawn to this, it became clear that members were experiencing strong affect from which they wanted to pull back before speaking. Exploring parallels to this, they imagined people pulling back from the patient throughout his life, including his mother at his birth.

Compassionate speculation dealt with the therapist's possible need to pull back to protect herself from emotional involvement with his deterioration.

After this group one member remarked that it had seemed like a group meditation.

We are highlighting the importance of atmosphere in the Balint group session. The spaciousness of this group allowed members to make contact with powerful emotional experiences. In that atmosphere of trust and many unpressured silences, the group discovered images and speculations to formulate impressions the presenter found meaningful, even though she had years of experience with this patient.

We have also noted how often, after presenting to a Balint group, the presenter returns to the group saying that something was different in the atmosphere between them and their patient. A non-verbal quality seems to permeate the doctor/patient connection resulting in a far more effective relationship even though there were no changes in the medical interventions.

Before we leave the topic of space for non-verbal experience, let us circle back to its psychoanalytic significance. Balint groups are not psychotherapy groups and do not follow the traces of an individual's development, nor do they claim to create new capacities in doctoring

that might parallel the early development of mind. However, we do believe new ideas or experiences must arise in order for the Balint work to accomplish its purpose, so creativity is relevant. Balint imagined that at the first level that mother and infant are in a state of primary love which "gives the individual 'a tranquil quiet sense of well-being.'" (Oppenheim-Gluckman, 2015, p24,) Optimally mother, and other elements of the external world, provide what is needed so that the infant is un-impinged on and unaware of otherness. From this place, something new may arise.

As Balint group leaders we want to create the conditions that most support creative process for the presenter receiving the group's reflections and for the group participants in their reverie. Following Balint's idea about the area of creativity, we protect the private space of the presenter during push-back and at the end when invited back in. Maintaining the group's focus on experience based associations and speculations also protects this private space by not introducing the moral tone of advice.

Another principle evident in Balint's psychoanalytic thinking which also influences our groups is trust in the presenter's process of receiving what the group offers. If, as Balint suggests, creativity arises out of an objectless state, we posit it is only possible when one's private inner work is trusted. As noted earlier, we believe it's important to protect the presenter from being asked to respond to the group and we take care early in a group's formation to state that the presenter, returning to the group after push-back, is not expected to report their thoughts. In fact, they may not want to interrupt their musings by speaking at all. Our experience is that most presenters are quite busy internally when they rejoin the conversation and many are grateful not to have to respond coherently.

We also find that giving the presenter privacy is useful to the creative process of the group as a whole because it lessens attention to whether details are correct and encourages confidence in the usefulness of their imaginative musings. Additionally, for the doctor to practice sitting back, softening their focus and pay attention to his or her own thoughts is a crucial skill of doctoring, especially when an encounter is not going well.

And finally, trust in the presenter's process keeps the leaders and the members of the group from teaching or advising. Until someone experiences presenting and then discovers their own change, it can be difficult to believe that not teaching and not advising are generous and helpful. After this experience, the lack of instruction is very welcome, as one of our new members explained, "It opens up whole worlds."

Balint groups offer contact with the limitlessness of minds reaching into unconscious associations - where experience rather than management is reflected upon. Doing this with colleagues for the long period of a group session prepares the practitioner to do it for a moment, as needed, in practice. (Lichtenstein & Lustig, 2006) Like Balint, we appreciate the parallel between early development and creativity. In the area of creation 'The subject is on his own, and his main concern is to produce something out of himself...' (Balint, 1992, p. 24)

Balint was a maverick in the field of psychoanalysis. Quoting Sutherland's obituary for Balint, "Balint may well be rated in the future amongst the first-rank original minds after Freud and his immediate circle... An appraisal of his work would be a major task..." (Balint, 1992, p. xiv)

We have not offered an appraisal but we hope to have shown that revisiting Balint's seminal thinking is worth doing. Our effort has been to connect Balint's psychoanalytic contribution to his group work and to offer insight into possible links between them.

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Michael Balint: Early Interventions, Early Groups

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Abstract

The paper discusses the early discussion groups organised by Michael Balint in the 1950s. While these groups preceded the Balint-groups proper, they represent "laboratories" where we can observe the emergence of the technique of Balint group interventions. Indeed, the early groups offer a privileged "window" into the development of the Balint group method. Based on several years of archival research in the Balint Archive, held by the British Psychoanalytic Society and based on the study of the transcripts of both the early groups of the 50s, and the established groups of the 60s and 70s, I elaborate on historical, epistemological, and technical aspects of the groups. In particular, I give special attention to the Discussion Groups held at the Tavistock Clinic, in 1951, led by Michael Balint and Henry Dicks.

My paper presentation in Porto aims to accompany an Exhibition which I am preparing for the occasion of the Conference, with the provisional title "A Window to the Early Groups", and which will show selected transcripts of the groups, alongside other historical materials held in the Balint Archive. As the Exhibition is in preparation, I will add relevant archive-related considerations to the paper below.

Connecting Threads: The Work of Countertransference

In Balint groups, the case is spoken, and the presentation is free-associative. Balint insisted on doctors' not using notes when making their presentations. In fact, in one of the early discussion groups at the Tavistock Clinic, in 1951, preceding Balint groups proper, there is a note on how Balint left the room when one of the doctors started reading a case-history prepared in advance. Balint allowed himself to make a quite sharp transference-wound here, so as to demarcate the particular kind of case-presentation that characterised his group method.

When the case is spoken, and presented to the group, the basic assumption is that there is something yet to be uncovered. Neither the presenter, nor his peers, nor the group leader know exactly is being sought. Furthermore, I would argue, comparisons between cases are

comparisons between cases of countertransference – between cases where what is examined is the unconscious response stirred in the doctor by their patient.

How might we make sense of this centrality of work on the countertransference to the Balint groups? This first step is to explore some Budapest School traces. For Ferenczi the psychoanalytic process was conceived as “dialogue of unconscious” (Ferenczi, 1932a, p. 84). The guiding image is one where transference and countertransference are part of a single system (Haynal, 1999).

One “Budapest trace” that I would like to evoke here is around the Polyclinic – a true free clinic – which opened its doors in December 1931, after years of struggle in the dire political times of Horthy’s regime. The Polyclinic had the same address as the couple Michael-Alice Balint: Mészáros utca 12.

Even before the opening of the clinic, Mészáros u. 12 was a well-known meeting place for psychoanalysts, writers and musicians. With the clinic, Friday meetings became regular, and they brought together Sándor Ferenczi, Alice and Michael Balint, Vilma Kovács (Alice’s mother), and also Endre Almásy, Robert Bak, Lilly Hajdu, Imre Hermann, István Hollós, Kata Lévy, Géza Róheim, and Lilian Rotter. The Polyclinic was a fully-fledged therapeutic and training establishment. Senior analysts gave lectures, and they were followed by a seminar in psychoanalytic technique, led by Vilma Kovács. Here, cases were presented and discussions on countertransference were given a key place.

It is here that Balint started his own explorations with groups of medical doctors; but he was still uncertain about the most suitable format for organising an encounter between psychoanalysis and medicine. He reflects at a later point that the theoretical lectures he set up proved “fairly useless” (Balint, 1970: p.457). He thus experimented with a seminar where the discussion focused on the everyday work of the medical doctors.

How was it possible to imagine that medical doctors and psychoanalysts fit together well in one room, and that they can learn from one another in a structured exercise? I would say that this possibility had to do with the creative epistemological ideas of the Budapest School of psychoanalysis, especially Ferenczi’s.

Ferenczi was cautious against the perils of a medical science that proceeded rigidly – as he puts it – by looking, as if hypnotised, into the microscope (1933, pp. 146-147). Ferenczi also proposed a horizontal model of the encounter between the sciences, where each scientific discourse has the attribute of bringing insight into a particular semiotic code, while none of the codes is deemed superior. The final chapter of *The Development of Psycho-analysis*, co-authored by Ferenczi and Otto Rank, brings a utopia of the unification of the natural and mental sciences, with psychoanalysis taking up the role of making the integration. As he writes, “If looking at scientific advance as a whole, we see that direct, rectilinear advance keeps coming to a dead end, so that research needs to be resumed from a completely fresh and improbable

angle” (1922, p. 371). This ethos of a non-hierarchical encounter between domains of knowledge influences Balint profoundly.

I believe Balint had close familiarity with the little known Ferenczian idea of the “utraquism of the sciences” [Utraquismus, Utraquistische Arbeitsweise], which is an expression of hope in the possibilities of a less rigid and less dogmatic materialism, that would allow the emergence of what Ferenczi called “psycho-physical parallelism” (Ferenczi, 1900).

But what is utraquism? Derived from the Latin *utraque*, meaning “one and the other”, it is the work of establishing relationships of analogy between distinct elements that belong to distinct fields of knowledge or strata of reality, with the aim of discovering or going deeper into the meaning of certain processes (Ferenczi, 1924). [...] Utraquism is for Ferenczi a method. It is an epistemologically consistent disposition.

In an interview given for a French journal, *Gazette Medicale de France*, Balint (1970) leaves a trace of striking genealogical clarity in relation to his groups method, which points us in the same direction: work on countertransference.

I decided to use my experience with the Hungarian system of supervision, and to work out a training in psychotherapy based chiefly on the close study by group methods of workers' countertransference. In order to be able to examine the latter in detail I had to create conditions in which it could be shown as freely as possible. I therefore did not tolerate the use of any paper material in the case conferences; the worker had to report freely about his or her experiences with the client, in a way reminiscent of “free association”, permitting all sorts of subjective distortions, omissions, second thoughts, subsequent interpolations etc. I used this report – as it is used in the Hungarian system of supervision – as something akin to the manifest dream text, and tried to infer from it the dynamic factors in the client-worker relationship shaping it. Both the second thoughts of the reporter and the criticisms and comments of the listening group were evaluated as a kind of free association. The real proof of the correctness or incorrectness of the reconstruction of what happened between the worker and the client in the interview was the subsequent interview, in the same way as the proof of a dream interpretation is usually the subsequent dream.

Early Interventions, Early Groups¹

While reading the transcripts of the GP Discussion Groups, held from April to June 1951, at the Tavistock Clinic, led by Balint and Henry Dicks, we realise that they are a laboratory for the emergence of the Balint group techniques. There are 10 weekly groups, with a participation of between 6 and 15 doctors (but more regularly 9 to 11 GPs are in the room). The transcripts are held at the Balint Archive at the British Psychoanalytic Society.

In the first meetings, the participants posed a set of questions of philosophical scope: what is gratitude? what represents an ethical posture of a GP? what is suffering? what is healing? As

meeting advanced, there was a move to presenting cases. The flesh of the cases emerged from the group of doctors turned onto their own practice. Balint did not make case presentations into a rule – he sometimes invited it for the next session – and the response was sometimes engagement and other times resistance and reverting to broader and more abstract concerns. The case, nevertheless, returns. The case anchors but also allows the medical imagination to work.

In these discussion groups countertransference becomes thinkable, without using the word "countertransference". We are met with the practical emergence of a field of work on countertransference, outside the classic psychoanalytic frame, and without the need of any theoretical exposition of what countertransference is.

There is a metaphor that Balint sets the stage with: it is a productive metaphor, it captivates doctors, draws them into a game of imagination. This metaphor is that of the "doctor-as-a drug", or more simply, the "drug-doctor". Already from the first meeting of the series of discussion groups I look at Balint states that the most frequently prescribed drug is the doctor himself and there is no pharmacology to date for this drug.

Let us see how this idea evolves in the early groups:

Dr Balint opened the discussion by summarising the discussion of the previous week. He said that the group agree that the most frequently prescribed drug is the doctor himself but we have no pharmacology of this drug. It is important to work out the effects of the doctor himself on the patient. Two different doctors may do the same thing but it would mean quite different things to different patients.

There was some disagreement last week on the importance of diagnosis in its own right. By attending too much to the question of organic diagnosis, the doctor may miss the importance of some psychological symptom. It was also thought by some of the group that physical illnesses are more dangerous than psychological illnesses and need more care.

Dr. Balint also mentioned the difference in approach to the patient of a specialist and his general practitioner. The G.P. has already developed a relationship with the patient, whereas the specialist has not got this advantage.

Following this introduction, a case was cited of the treatment of [...]. This was treated by calcium injections but the doctor concerned thought that the real therapy was not the calcium but the psychological effect of the injection, the patient tuned up again for the same treatment exactly one year later, saying that it felt so wonderful last time that it must have been doing her good. Other members discussed the possible bad effects of excessive calcium treatment and the point was raised that intra-venous calcium injections are more effective and intra-muscular. [...]

At this point the notion of the psychological significance of an injection [...] was introduced. Dr Dicks commented that in Britain the inviolability of the person is important. An injection might

be taken as an assault or an attack. How far can a doctor go in transgressing an individual's right in this respect? From associations of adult patients, it is known that doctors are often associated with attacking figures. The injection may therefore activate phantasy systems in the patient. It is important for us to discuss how far we are regarded as being bogies, having a double function, punitive and healing.

(G.P.s Discussion Group, Second Session, Thursday, 26th April 1951, The Tavistock Clinic; transcript held in the Balint Archive of the British Psychoanalytical Society, London)

What is relevant – and radical – in the metaphor "the drug-doctor" is that the analyst and the doctor are not confined to an Oedipal story, they are not strictly mothers and fathers, but they can also take the place of a substance or an artefact.

Balint seems committed to a kind of psychoanalysis where the physical mash of things matters as well. In "Gratifications and Object Relationships", a chapter of his 1968 book *The Basic Fault*, Michael Balint writes (1968, p.136):

The air is not an object but a substance, like water or milk. [...] there are a few – not many – more such substances, among them the elements of the pre-Socratic philosophers: water, earth, and fire; with some others used in present-day guidance clinics, such as sand and water or plasticine. The chief characteristic is their indestructibility. You can build a castle out of wet sand, then destroy it, and the sand will still be there; you can stop the jet of water coming from a tap but, as soon as you take your finger away, the jet is there again, and so on.

The analyst's role in certain periods [...] resembles in many respects that of the primary substances or objects. He must be there; he must be pliable to a very high degree; he must not offer high resistance; he certainly must be indestructible, and he must allow his patient to live with him in a sort of harmonious inter-penetrating mix-up.

Also, Balint punctuates the discussion (indeed, he interprets) in a way that converges around countertransference: Do doctors select their patients? What does that mean, that doctors select their patients? What does it mean that a doctor "clicks" with a patient – to use the language of one of the doctors in the group? What is the nature of this experience of "clicking"? Do doctors expect forms of gratitude from the patient? Is there a core of guilt in this expectation?

Balint states during the discussions that there are different techniques to be adopted. One is educating the patient in responsibility toward his illness. This he will later refer to as "the apostolic function of the doctor". The other is adopting the attitude "I know best – have faith in me". This is the paternal function. Naming the apostolic function and working on the way it is lived in the doctor-patient relationship means opening for investigation a field of power that was compacted, foreclosed. In other words, Balint identifies a field of power.

1. This section will be adapted to accompany the Exhibition materials. I offer here a summary of what I intend to present in Porto.

Cap. 04

Implementing Balint Groups in Medical Systems

Seeing the Outline of a Star

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Abstract

The paper interprets de Medonça's and Rilke's window trope through the application of Goethe's delicate empiricism, involving what Melanie Bradley describes as 'using empathy, imagination and intuition to promote a participatory engagement'. The author invokes Ondaatje's depiction of a jazz musician's traumatic encounter with the window as boundary, and advocates vision influenced by the outline of the star left when the window was smashed, a traumatic encounter from which we might otherwise retreat. From this viewpoint, the author describes the situation in which he works in public sector psychiatry on the New South Wales Central Coast, and the process of development and practice of a four meeting trial of a multidisciplinary Balint-method clinical reflection group for the staff of an acute adult inpatient mental health unit, with the multidisciplinary nature of the group enabling the possibility of seeing medicine through other eyes, while acknowledging the outline of a star.

Seeing the Outline of a Star

Melanie Bradley (2011), in a paper assessing the value of Johann Wolfgang von Goethe's 'delicate empiricism', cites Goethe as 'using empathy, imagination and intuition to promote a participatory engagement with the world.' (p81)

In another paper on Goethe's empiricism, I wrote of Michael Ondaatje's portrayal of jazz cornetist Buddy Bolden pulling 'back from an angry punch with the realisation that it would be the window he would be hitting. With the realisation that the window functions as a boundary, the crossing of which portends injury' (Leggett, 2009a), Ondaatje writes:

His open palm touched the glass, beginning simultaneously to draw back. The window starred and crumpled slowly two floors down. His hand miraculously unhurt. It had acted like a whip,

violating the target and still free, retreating from the outline of a star. (p16)

The theme of the 21st International Balint Federation conference, held here in Porto (2019) is 'Balint: Seeing medicine through other eyes.' The website, which states the conference theme in a quote from an English translation of de Mendonça (2017), suggests that this theme is to be interpreted via the trope of the window as not only '... a simple thing, a hole ripped on a wall ...', but '... a sort of passage for the eye ...' De Mendonça cites

Rilke's poem in which the window is seen as a 'simple form/ that effortlessly circumscribes/ our enormous life.'

Rilke (1982), in the first of the Duino elegies, has it that: '... Often a star/ was waiting for you to notice it. A wave rolled toward you/ out of the distant past, or as you walked/ under an open window, a violin/ yielded itself to your hearing ...' Even here, Rilke has the star waiting to be noticed through an open window, and not through one that has been breached by violence. But if we are to look, via the Balint clinical reflection method, at Medicine, through other eyes, it might be that we look through the window, acknowledging it as a passage for the eye, without ignoring that we are looking through a hole, and that the outline that is left of the star is that of violent rupture. The outline of that exploding star may be noticed by one who is open to seeing that star as a scar, as traumatic memory of a breach, as a wound which may be unhealable, but with which we might engage, via the Balint method, especially in the context of an interdisciplinary clinical reflection group, 'using empathy, imagination and intuition' (Bradley, 2011, p81).

Returning to public practice psychiatry at Wyong Hospital on Central Coast New South Wales, I was looking for a window of opportunity through which to introduce Balint clinical reflection processes to my clinical team—those processes that have enabled me to view the ailments of patients; of colleagues in the travail of clinical engagement; and even those that might lie, as primal wound or basic fault (Balint, 1992) at the base of my own sense of failing.

Looking at the work through such a frame, one that holds a broken window, makes it possible to see the traumatic rupture that has occurred for our patients, the outline of the star left by that rupture, and the trauma of their admission to a hospital mental health unit as reenactment. Awareness of that rupture in one's own experience opens the window to seeing, through 'empathy, imagination and intuition' (Bradley, 2011, p81), the outline or scar of that star in the patient's experience of the hospital admission, and to the parallel processes that might arise when group members, with awareness of their own traumatic experience, meet together to reflect on interactions with such patients.

Our local health district has two hospitals with inpatient mental health units, one at Gosford, and the other at Wyong. They service a population of about 330000 people living on the coast stretching from the mouth of the Hawkesbury River to the southern outer suburbs of Newcastle, with forested mountains and the Tuggerah lakes to the west. Gosford has the appearance of an urban regional hub, whereas Wyong to the north spreads along the beaches and the lakesides

as a series of smaller and poorer pockets of development. In contrast with multicultural Sydney, the vast majority of the Central Coast population are of British and Irish decent, and most of the rest are of other European ethnic origins. About 3.8 per cent claim Australian aboriginal ancestry. Their life expectancy remains about 8 years less than that of the general population, although all our administrative meetings begin with an acknowledgement of elders past and present, and that we convene on their traditional lands.

Most of the patients presenting to emergency departments at Gosford and Wyong hospitals for mental health assessment are from the local area, but we also have patients passing through from Sydney, Newcastle and further afield. In Australia, we have universal health insurance, with free care provided by public hospitals and state-run community health facilities, but primary care and much specialist outpatient medical care are provided by private practitioners. Private care is not free, but is subsidised by the universal government health insurance scheme, Medicare. Central Coast has a relative shortage of private health services, with some general practices requiring patients to wait several days for appointments. There are few private psychiatrists. Services for mental health care of children and adolescents are especially scarce. There is a disproportionately heavy load on emergency departments, public hospitals and community mental health services.

Unfortunately many of the presentations to our emergency departments and inpatient mental health services are influenced by intoxications and psychoactive substance dependence. Emergency staff, nurses and doctors working in public mental health are frequently engaged in attempting to contain and prevent aggression and self-destructive behaviours in patients whose illnesses are either directly caused or substantially exacerbated by substance misuse. Homelessness and domestic violence are also problems in the region. Housing prices and rents are high, as are rates of unemployment and dependency on social welfare. In spite of these difficulties, and the shortage of public and emergency housing, we manage to keep the average length of patient stay down to about fourteen days.

Each Friday at lunchtime, the Central Coast Local Health District has Mental Health Grand Rounds. I took the opportunity to volunteer to present on Balint clinical reflection work when a colleague cancelled a presentation at short notice. I began by offering a brief introduction to the lives and work of Michael and Enid Balint and an account of my own experience developing and leading a multidisciplinary Balint group in a community mental health setting (Leggett 2009b, 2011, 2012). I then outlined the structure and process of a Balint group meeting, with a hypothetical case, using my adaptation of a power point presentation offered by Ritch Addison at the Balint leadership training intensive in Portland, Oregon in 2012. My presentation generated interest from nurse managers, educators and administrators with experience in another kind of reflective clinical practice. They were curious to learn more about the Balint process. This led to an invitation to lead and to join with nurse managers and educators in planning a trial of a multidisciplinary Balint clinical reflection group for the acute adult inpatient mental health unit staff.

The trial group was to meet four times, at fortnightly intervals, at the time scheduled for nurse

education sessions. The unit managers and the nurse educator would support me in planning, time keeping and debriefing my leadership after each meeting. We decided to begin with a group of fifteen invited participants. Several nurses were identified as open to group exploration of the emotional and psychological aspects of their interactions with patients. I proposed that my consultant psychiatrist colleagues, our three trainee psychiatrists, our social worker, our psychologist and our occupational therapists should also be invited to join the group. It was agreed that while the group would be meeting in time protected for education of clinical nursing staff, the nurse managers, medical and allied health professionals might occasionally need to leave the group to address urgent calls. This concerned me, as I would be leading the group while my unit was rostered to respond to new presentations. I would be obliged to remain available to advise per telephone in emergency situations.

An invitation was circulated, together with a participant information sheet containing the essence of my grand rounds presentation with a pro forma of the sequence and process of the meeting, allowing for a five minute assembly time, a forty-five minute case discussion, and completion of a six-item, five-point Likert scale evaluation sheet, the same one that I had previously used with my collaborator Stephen Parker for our research on short-term medical student groups (Parker & Leggett 2012; 2014). As leader, I completed the same evaluation sheet as the participants, using this as means to compare my own self-evaluation with those of the participants on leadership, group process and educational benefit.

In addition to the nursing colleagues planning the group with me, three other nurses responded by committing themselves to the trial of the process, as did one each of the trainee psychiatrists, consultant psychiatrist colleagues, an occupational therapist and the unit psychologist. The group would be multidisciplinary, with doctors in the minority. This opened a window to the possibility of seeing the process of our work together with the patients, through the eyes of the direct clinical nursing staff, nurse managers, and allied health professionals, and not only through those of the medical staff.

The first meeting was attended by all but one of the agreed participants. None, other than I, had any previous experience of Balint processes. My call for a case was followed by a lengthy silence. Then one of the nurse managers mentioned the concerns she had over the journey of an ambivalently pregnant young woman patient with substance misuse problems and a psychotic illness. The case was accepted. A seven minute presentation followed, with three minutes allocated to questions of matter of fact, after which I asked the presenter to push back her chair and observe the process of the group discussion. Nursing members of the group offered their experiences of interacting with the patient, while the medical practitioners chose to remain silent. I intervened a number of times to counter a tendency to move away from accounts of emotional responses to direct interactions towards instead discussing the ethical dilemmas regarding medical indications, as well as humanistic and religious values surrounding termination of pregnancy, decision-making capacity and capacity for mothering. I tried to bring the groups' focus back to balancing imaginative speculation on practitioners' and patients' emotional and psychological experiences. Psychologically minded contributions by the psychologist and occupational therapist aided the group in refocussing on intuitive processing

of relational issues. As we progressed, I found nursing members beginning to risk expressing something of the anxieties their interactions with the patient evoked, and empathic speculation with respect to the emotional experience of the patient. The group progressed towards seeing the brokenness in the patient and the situation, and to be able to empathise with and speculate on the patient's traumatic experience, to see and to look through the outline of the star. This was especially pronounced when the nurse manager who had offered the case was invited to rejoin the last few minutes of the group discussion.

With Christmas approaching, annual leaves, shift rostering and staff shortages took a toll on attendance at the next meeting. As there were only four attendees, I advised that we should cancel the meeting and reconvene early in the New Year. We briefly discussed the need to stabilise room bookings and to endeavour to roster participating staff on duty at the time of the meetings.

The third meeting, soon after New Year, was attended by five participants. I decided to proceed with a method modified to include the presenter throughout the discussion. The case presented by another practitioner was a patient of my own, a situation which will arise sometimes, as I manage a third of the patients on the unit. The absence of an experienced coleader or alternative leader came sharply to my attention in this situation. My own anxieties about this, and interruptions to participants due to matters of urgency, served to increase the sense of chaos and potential futility that pervaded the group in discussion of the case: another young woman with psychosis and psychoactive substance addictions. The need to ask colleagues not participating in the group to cover calls for me, to help me to protect the group time for myself, presented itself as a blind spot in my planning. I reflected on the way in which, by stepping into such a situation without protection and support, I was risking my own and the group's retraumatisation, with that trauma potentially staring out, as though from Buddy Bolden's blow to the window. By seeing the outline of that star, I was able to take such measures to establish and protect the possibility of a safely reflective group space.

At the fourth meeting, which seven participants attended, the case presented was an after-hours emergency intervention for a child in foster care, regarding whom all but the host parents seemed to despair. Sensing feelings of powerlessness and potential futility in the presenter, I asked him to remain in the discussion, rather than be pushed back to observe. I found myself having to protect him throughout the meeting from intrusive interrogation. Frustration expressed by group members at the apparent lack of ownership of the case by limited availability of community services seemed to reflect the growing despair of the child's carers with respect to their chances of making a positive difference.

There was much sadness expressed, including sadness that the presenter was about to leave the team, having provided valued clinical service and collegial support. The group progressed away from the interrogative stance, towards support of the doctor presenting, with acknowledgement of his capacity for understanding and empathic consideration of the child and his foster carers. Nursing and allied health perspectives seemed to ease the presenter's

apparent distress at not being able to do enough to substantively change the outcome for the child.

I was glad I had not asked the presenter to push back. The group seemed to be working together to protect the presenter against retraumatisation and demoralisation, while deciding not to turn away, and to hold instead to a vision of brokenness, sustaining compassion through recognition of the limitations and the difficulty of even looking at, let alone repairing, the damage done. I considered the group to be moving towards seeing the outline of a star.

After the other participants had dispersed, I was aware of distress awakened in me by the case, and so needed to debrief with the nurse managers. Then we discussed the future of the group, as the participants remaining in the service had expressed a wish to continue. All evaluations had been positive, averaging scores of at least 4/5 in response to each of the questions. My own evaluations had been a little less positive, especially with respect to the issue of the group experience influencing change in my clinical practice. So we decided to continue, addressing the need to include a greater number of participants if the group is to sustainably function. It was decided that a wider group, including new graduate nurses and the junior doctors doing ten week rotations in psychiatry should be invited, with the aim of closing on a group of fifteen to twenty committed participants. With leave and rostering considerations taken into account, that should enable our desired attendance of about ten participants at each meeting.

Participants in our group are aware of me presenting our work to you at this time. We hope that work will continue and I will be able to present our progress to the international community at future conferences, enabling us to benefit from your feedback and your support of my leadership, which I hope will be enriched and improved by what I come to be able to see, as your eyes recognise the outline of the star that remains where the window that I provide for you to look through was shattered by forgotten, even ordinary trauma, and the basic fault that both enables and inhibits our work.

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Balint Infrastructure in a Large Tertiary Hospital In Israel

A paper presentation for the Porto Balint conference

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Abstract

Ten years ago, a pioneering project started with a Balint group for psychologists in a tertiary hospital in Tel Aviv. The Aim of the group was to experience Balint work and train future Balint leaders for the hospital.

The group is still running, by now, it's a mixed group of psychologists and physicians. Graduates of this group formed and led about twenty Balint groups at different wards and for different health care professions. There are 15 active leaders, and 15 participants of the experiential group. At any given time, there are 5-10 active Balint groups at the hospital.

The Balint infrastructure at sourasky medical center, consists of the experiential group, a training course for leaders, individual and group supervision and a Balint forum.

We have learned how to plan and start a Balint group in hospital setting. Some of the factors predicting a successful group are: appropriate needs assessment, flexible setting, a dedicated "change agent" and getting supervision.

Balint Infrastructure in a Large Tertiary Hospital In Israel

It takes a village

Tel Aviv Sourasky Medical Center (Ichilov) is the largest acute care facility in Israel, treating about 400,000 patients and hosting 1.8 million patient visits per year. A 1500- bed academic medical center, serving a population of one million people and acts as a national referral center across a range of medical and surgical disciplines.

The Balint in Ichilov, started some 10 years ago when Naomi Yoeli, a clinical psychologist

and a Balint leader, realized there is a need for doctors to deal with the emotional burden related to their work and for psychologists to enrich their abilities in organizational interventions. She asked Dr. Andre Matalon, a family physician and an expert Balinter to join, and they started the first Balint group for psychologists in the hospital. The aim of the group was both to let them experience participating in a Balint group and to grow future group leaders.

Two years later, I was asked to take Andre's place as leader of that group.

As time went by the psychologist gained experience and started running Balint groups. We founded a supervision group to answer the needs of the new leaders.

Naomi and I co-led the experiential and the supervision groups until Naomi had to leave Ichilov and Galit Argov a clinical psychologist and a veteran of the first group took Naomi's place. Another graduate of this group, Meirav reicher a medical psychologist helped run the Balint activity for a few years, then moved to another hospital.

I am going to describe in details the different structures of Balint in Ichilov and share our understanding of establishing and maintaining a Balint service for a large hospital.

The Hospital Balint infrastructure and its products

Balint work in Ichilov runs under the psychology service. This framework was created to produce Balint groups for different health care professionals at the hospital. Along the years, as activity expanded, the "Balint infrastructure" was built, assembled from different units that were created along the years when we encountered new requirements.

The units of this mechanism are: Experiential group, Formal Balint leadership training, private and group Supervision and the Balint forum.

The experiential group

The group operates as a classic Balint group and meets once a month. One difference takes place at the end of each meeting. The last ten minutes are dedicated to "observations on the work of the group", allowing the members to reflect on how the primary task was achieved or not, on the process and on the leadership.

Naomi and I adopted this technique from Daniella Cohen. We find it is very useful in other groups and especially important for participants that later will become leaders. It asks the participants to think about the role of the leaders, about the task of the group and about ways of achieving that task.

At the end of a year, after nine meetings, veteran members leave and new members join. A specific concern for this group is that it forms a new group every year. We have to pay special

attention to the group dynamics and the different levels of Balint language among the novice and expert participants, as well as the difference between psychologists and physicians.

Psychologists are asked to participate for a minimum of three years and physicians for at least one year.

Thirty seven health care professionals have attended the experiential group until now. Twenty nine psychologists (20 medical, 5 clinical, 4 rehabilitation), 7 physicians and one nurse.

Supervision group

The supervision group started its life when few groups started in the hospital and a need for supervision was expressed. Naomi and I started it and it has been meeting once a month for 5 years now. Every Balint leader is invited to join the group. The supervision is done in Balint style. One or two leaders present a case, which is a group, the relations in focus are the relations between the leaders and the group. The group is asked to free associate, share ideas or feelings regarding the dilemma or question asked. The particular setting of a hospital Balint group in which group members have prior knowledge of the presenter or the case, recurs in the supervision group, in which there is an intimate acquaintance with the presenter and the personas presented in the supervision case.

We encourage the Balint leaders to present groups in planning, while going or after the group have stopped working. The knowledge accumulated on Balint groups in a large hospital is kept not just with the leaders or the Balint forum but also with the members of the supervision group. We have learned a lot from successful groups and have learned more from the ones who did not succeed.

A total of sixteen psychologists and 3 physicians attended or still attend the group.

Training program

The need for a training program appeared when physicians were asked to start leading. As opposed to psychologists who based on their professional training, found it natural to start leading a Balint group, the physicians found it more challenging. They claimed they are not familiar with the jargon of group dynamics and psychodynamics, as well as lacking basic skills in group leading.

Having in mind that both professions will benefit from a formal training, we designed a short Balint leadership training. A two days seminar in which both physicians and psychologists, veterans of the same experiential group, take turns and volunteer to lead the rest of the group in a 45 minutes Balint group. After which another 45 minutes are spent on observing and learning

leadership.

In between groups, short segments on theory were introduced by experienced Balint leaders. The topics included: The history of Balint worldwide and in Israel, group dynamics and transference, basic Balint settings, dilemmas in leadership and how to start a new group in a hospital.

The training program got good reviews and felt to be useful.

Individual Supervision

In the last year we added the final component of the Balint infrastructure which is the individual supervision for new leaders. It is provided twice a month by a senior member of the team and is given to the two leaders, dealing with more concrete needs (How to...? What is...? How do I...?). These needs cannot be met in the supervision group in which one can only present a group once every several month and a different method is used.

The hospital Balint forum

The forum includes the heads of the psychology service, the leaders of the experiential and supervision groups and an experienced leader in charge of administration. The forum meets four times a year. Its main task is policy making. It defines goals for Balint work and inspects the results. The forum decides on new groups, selects the leaders and chooses new participants of the experiential group and of the training program.

Groups (past and present)

About 15 groups has been running in the hospital since the Balint project started. Some last for years and some have only lasted a few meetings. Many more were planned and didn't start for different reasons.

Some of the groups include: Medical Oncology for medical residents, Oncology day care for nurses, Hemato-oncology – multi sectorial, several Internal medicine wards for physicians and one for students, geriatrics and palliative medicine, IVF – Multi sectorial, and for nurses in orthopedics, oncology, Pediatric intensive care unit, general intensive care unit, dialysis and rehabilitation day care

Lessons learned

Hospital differs from community in tempo and in scale, the intensive work is done around the clock and patients are in acute and critical condition. Hospitals are based on teamwork and the physician in the community works alone.

Balint work in a hospital is also different than the one known to us from the community.

After almost ten years of Balint in a large hospital, we now know more about these differences.

These are the points we found related to creating and maintaining a stable working group in a hospital.

Needs assessment

The Balint primary task is exploring patient doctor relationship. The conditions should allow for that to happen. Under staffed, overworked hospital unit or one in which the head nurse and the ward manager are fighting might need other treatment prior to having a Balint group.

In our oncology group, the residents were so affected by young people dying, exposure to constant grief and death anxiety. Receiving no emotional support, made it almost impossible to deal with relations.

The group composition Unit managers

Can managers be in the group? Sometimes the group will not form without the head of the unit. On the other hand some participants might not feel free to express their thoughts or emotions when someone who might decide about their future is in the room. At the first year of the experiential group, the head psychologist and the head of medical psychology, participated in the group. Both the leaders and the participants felt it hindered the work of the group, the leaders intervened, asking them not to take the role of managers or supervisors in the group and eventually it was decided that they cannot stay in the group. In another group a senior physician who requested a group for the residents insisted on participating. She wanted to see how the residents were doing and wanted the Balint "treatment" for herself. It is common practice now. To not allow the manager join the group.

Mixed group from different units of the hospital we plan on opening one soon. The rationale is that safe, free association, unconscious work is essential for Balint work and is more difficult to achieve in an organic unit.

Leader from within the unit

The disadvantages of having the unit psychologist lead the group should be considered, even when there is a co leader from outside. On one hand, knowing the leader, the group members and the patient presented, reduces space for unconscious work and influence transference. On the other hand a known leader might help create trust and safety in the group.

Other professions

We had groups for different professions, such as, Medical secretaries, study coordinators, lab workers and radiation technicians. One of the first groups was for oncology research coordinators who dealt with dying patients on a daily basis. That group did not last long, the coordinators felt, overwhelmed by talking to dying patients about medical trials, the chances of living longer, of getting placebo or of dying. Both the participants and the leaders felt like they were abusing Balint so that the coordinators will be able return to the front and perform.

Inter sectorial

Pros and cons of a mixed group should be considered. Emotional safety is important. "Will the nurse still trust me after she heard I hesitated in the last resuscitation?", "can someone from a different profession really understand me?"

Setting

A right sized, quiet room is needed, one that is always allocated to the group. It should be known that other staff members and patients cannot disturb the group.

Almost all of the rooms available had a table at the center. We had to adopt to working with barrier in the middle of the room.

An ICU nurses group, sat in a room that was equipped a screen, monitoring vital signs and heartbeats of all the patients. The blipping sound took the nurses attention who could not concentrate when the heart rate changed.

Group for nurses had to be timed between shifts and when the group meets, the ward is left without most of its nurses.

For physicians the schedule is more erratic, they are absent after a night shift and they are moved from one assignment to another quite often.

We recommend defining a finite time for the group to run (6 month, a year) with an option to renew contract at the end of the period. Thus preventing anxiety from committing to an endless process.

We interview applicants for the experiential group and in no other group. We do advise to interview applicants in all groups. This helps create an initial contract and set the goals and expectations and define the rules and method. If possible, selecting the more psychologically minded participants and excluding potentially destructive participants seems like a good strategy.

Communicating on administrative issues can be done by instant messaging applications.

Other notes for hospital groups

Tempo difference

Be aware of the pace. It takes time to start a group. Finding the right leaders, assessing needs and to finding the right place and time. The expectation is to have the group running very soon after the need was noticed and the request was made.

Ideally a group would meet once a week or every two weeks, Hospital tempo does not allow that. Most places would only be able to meet once a month, maintaining a process when meeting once a month is difficult and the leaders should be aware of that.

It should be appreciated that the hospital sets time for the group on working hours. Stating that the emotional wellbeing of the workers as well as the doctor patient relations are very important.

Other form of tempo differences to be noted is in the speech, is there room for silence, does the group seek an immediate solution as customary in hospitals, how long can the group stand incompetence of the presenter, of the group, of the leaders?

Important functions

Two functions within the unit are important for a group to succeed, one is an "anchorperson" who is the change agent and usually the one interested in having the group from start, the other is the manager who should be dedicated to the Balint task. The two functions are sometimes served by the same person.

Need for supervision

It is obligatory for every group leader to attend the supervision group. Individual / co leaders

supervision is offered to selected leaders.

Measurement

It is recommended that each group will be evaluated at the beginning and at the end (or annually) either qualitatively or by quantitatively. Methods such as the ProQOL questionnaire (Professional Quality of Life Elements Theory and Measurement) is available upon requesting permission.

Flexibility vs rigidity

Almost every group evokes questions about the group tasks and content allowed. Will we choose traditional Balint or use a more didactic attitude? Can we address group dynamics and interpersonal interactions? Can we act as organizational consultants? Can we allow cases that are not doctor patient related?

Can we allow drinking or eating in the group? are mobile phones allowed? Can the group start a bit later because rounds lasted longer? Can a member enter if he comes late?

These issues are to be discussed between the leaders and in supervision, too rigid or too flexible does not allow the group to form and work.

Conclusion

The Balint work in a large hospital is a challenging and rewarding experience.

Careful attention to the emotional needs of health care professionals is crucial, maybe even more in a hospital setting. The hard work associated with forming a Balint group or Balint mechanism in an organization as was described in this paper is enriching and gratifying.

The core of this work is being in a relationship and exploring together its emotional aspects. Starting with the doctor patient relations that continues into the leaders and the Balint group relations and ending with the supervision group leaders and the members of that group - the Balint leaders of the hospital.

The fruits of the hard work are seen within the hospital where Balint is now well known. It shows that the professional and private lives of group members are affected by it. Other hospitals in Israel ask for Balint groups of their own, a demand that will soon be almost impossible to supply.

Cap. 05

Providing Support and Preventing Burnout

Prevention of Professional Burnout in Psychiatric Hospital Medical Personnel: A Look at the Psychiatry Through Doctor-Patient Relationship

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This report focuses on the analysis of professional burnout in the medical personnel of No.1 N. A. Alekseyev Psychiatric Clinical Hospital, Moscow Healthcare Department. It reviews specialty- (doctors, nurses, psychologists) and work experience-related indicators of professional deformation. The report describes Balint group work as a method of prevention of professional burnout, while also citing statistically important results demonstrating a decrease in professional distress in medical personnel who attend Balint groups.

Keywords: professional burnout, Balint groups, psychiatric hospital medical personnel, doctors, psychologists, nurses.

Introduction

The use of Balint groups in preventing professional burnout has a long history started by their creator, M. Balint, dating back to the 1950s when he began to conduct London-based "seminars for doctors, consultants and social workers", which later became known as "Balint groups". In our country, the use of Balint groups also has a long history; attempts to use and popularize Balint groups have been made for about 30 years now – starting from the 1990s.

Today Balint groups are a popular method of preventing professional burnout; they are widely used abroad to work with people whose professional activities are associated with intensive and close communication with clients and patients, as well as emotional overstrain (here belong doctors, priests, teachers, lawyers, social workers, police, psychologists, psychotherapists, etc.). Abroad, Balint groups are also used as a part of the student training process, specifically, in training medical students, allowing the young specialists to learn about ways to prevent professional distress in the very beginning of their professional development. Our study revealed high levels of anxiety and occupational distress among the students of the Sechenov 1st Moscow State Medical University who're just starting their professional path, which indicates the need for special classes to cope with professional distress.

However, it is no secret that today in Russia Balint groups are more popular as a training program rather than a real mechanism to combat professional burnout. Supervisors believe Balint groups to be more costly compared to short-term trainings or less effective than such trainings. The helping professionals' attitude to holding and participating in Balint groups is rather controversial. First of all, such work - Balint groups are termed as a "group research method" - requires self-discipline and certain investment of time and emotion, which makes it different from a short-term training where the training leader often has to act as an "entertainer" to draw the audience in and convince students of the effectiveness of his program.

Our work aims to gauge the effectiveness of Balint groups and assess their benefit for the participants in terms of a long-term program for prevention of the professional burnout in psychiatric hospital personnel.

Professional activity of healthcare workers involved in the treatment and rehabilitation of patients implies major responsibility for their life, often requiring urgent decisions, ability to retain competency and maximum productivity under extreme emotional pressure. At the same time, it's important to be able to gain the patients' and their relatives' trust, show kindness, and demonstrate essentially psychotherapeutical skills, considering the fact that mental health patients usually undergo a lengthy treatment which requires special attitude and understanding^{3/4}.

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 too: mental health care workers are reported to show high levels of professional dissatisfaction,

depersonalization, and decrease in emphatic ability. According to researchers, dealing with psychologically difficult patients contributes to the emotional burnout in doctors and nurses. Here belong unmotivated patients, as well as those resistant to therapy or those given poor prognosis, which is often the case in psychiatry and narcology^{3/4}. According to the research, 96% of nurses working with cancer patients manifest different stages of emotional burnout syndrome; every second nurse (67%) shows "reduction in fulfillment of professional duties" which proves the negative effect of the emotional burnout syndrome negatively on the quality of nursing assistance⁵.

An overview of varied works shows a lack of coverage on the emotional burnout in mental health nurses; at the same time, the mid-level healthcare personnel are the ones who work with patients which puts them in the high-risk group. However, G.N. Uvarova's⁹ work shows mental health nurses to be less subject to professional deformation than surgical nurses. In psychiatric practice, it's especially important to closely observe the patient (lest he harms himself or those around him) and adhere to sanitary regimen. The nurse must be able to spot verbal and non-verbal signs indicating the patient's condition, as well as spot changes in the latter's emotional state. E.Y. Lazoreva and E.L. Nikolaeva's work⁶ shows correlation between the severity of the professional burnout and duration of work in a mental clinic. According to the authors, the group with under 10 years of work experience was under higher risk of emotional depletion and depersonalization, manifesting loss of interest in 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 one's professional incompetency.

According to the work by I.V. Arlukevich¹, based on a research held at No. 1 N.A. Alekseev Psychiatric Hospital, Moscow Healthcare Department, professional burnout syndrome, which tends to develop over a long period of time, is especially frequent in the nurses with a significant work experience (20-30 years). Although they enough experience to perform their professional duties, the bodily readjustments and apprehensions over their pre-retirement age these nurses are going through yield a negative effect.

Methodology and Methods

In 2015–2016 we conducted Balint group sessions with regular and senior nurses of No. 3 Psychiatric Clinical Hospital in the framework of a 4-year project Balint Groups for Psychiatrists, Medical Psychologists and Nurses. The study involved about 300 specialists. Since 2017, we've been conducting Balint groups with psychiatrists, heads of departments, medical psychologists, regular and senior nurses of No 1 N. A. Alekseyev Psychiatric Clinical Hospital. This project is conducted under the patronage of the head doctor of No. 1 N. A. Alekseyev Psychiatric Clinical Hospital, the chief psychiatrist of Moscow, Professor Georgiy Kostyuk.

A total of 14 Balint groups were formed; each group had 40 academic hours and a total of

7 group leaders. Two Balint groups were formed for department heads, two groups for senior nurses, five groups for nurses and five groups for psychiatrists and medical psychologists: a total of 200 specialists - department heads, psychiatrists, medical psychologists and nurses. The study involved 134 nurses, 21 psychologists and 37 doctors. 110 of them were diagnosed after Balint group sessions (64 nurses, 10 psychologists and 36 doctors). The average age of the group sample was 43.3 years, with average work experience in psychiatry of 13.4 years. The percentage of men in the sample group of 21 people totaled 10%.

The following techniques were used to determine the degree of professional burnout: Vinokur's AWPB (Attitude to Work and Professional Burnout) test and the Maslach Burnout Inventory test, as well as Seashore's Group Cohesiveness Index, Heim's coping strategies diagnostic method, the Stolin self-attitude questionnaire, and the Freiburg Personality Inventory questionnaire: they allowed to more accurately determine various aspects of the professional burnout and effects of Balint groups. We provided our students and Balint group participants with questionnaires which they filled out before starting Balint group sessions; another questionnaire was filled out after the last session.

Results of Research

This report will focus on the effects of the long-term Balint groups on professional burnout, which is primarily determined by the AWPB test.

This technique was proposed by V. Vinokur in 2012.

Our research proves it to be an effective diagnostic tool for professional burnout. The test offers an assessment of professional burnout on nine scales:

1. Emotional exhaustion
2. Work strain
3. Job satisfaction and assessment of its significance
4. Professional perfectionism
5. Self-assessment of work quality
6. Help 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).

In our study, the following results were obtained, as shown in Table 1 and Figure 1.

	1	2	3	4	5	6	7	8	9	IIPB
Before BG Sessions	49.8	50.7	44.4	51.9	44.1	44.5	41.4	44.6	49.6	48.3
After BG Sessions	41.5	40.7	41	45	38	44.3	38.9	40.2	41.7	41.5

Table 1. Assessment of the level of professional burnout (AWPB) before and after Balint group sessions (total sample)

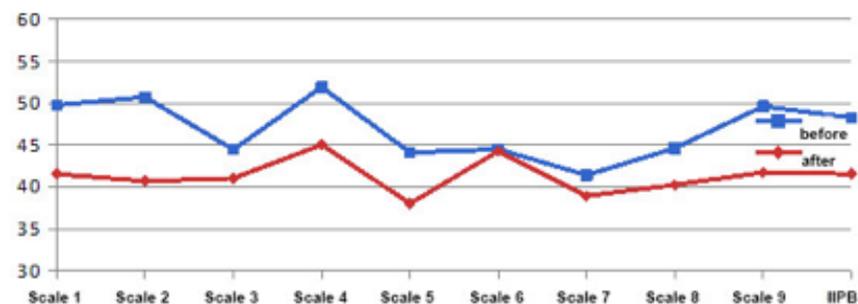


Figure 1. Assessment of the level of professional burnout (AWPB) before and after Balint group sessions (total sample)

After Balint group sessions, the total sample group showed significant improvement on the following scales: emotional exhaustion, work stress, professional perfectionism, self-assessment of work quality, overall self-assessment, health and general adaptation, the general integrative index of professional burnout as well as the emotional burnout index (based on the Maslach Burnout Inventory test). (see Table 2)

	t-value of equality of means				95% confidence interval of the difference of means	
	t	2-sided significance	Difference of means	Standard error of the mean	Lower limit	Upper limit
AWPB_I	5.066	.000	8.24148	1.62675	5.03885	11.44411
AWPB_II	3.282	.001	9.97927	3.04050	3.99337	15.96518
AWPB_III	1.671	.096	3.34133	1.99936	-.59486	7.27752
AWPB_IV	5.265	.000	6.92732	1.31567	4.33713	9.51751
AWPB_V	3.792	.000	6.08627	1.60492	2.92662	9.24591
AWPB_VI	.101	.920	.20144	1.99900	-3.73405	4.13692
AWPB_VIII	2.870	.004	.20144	1.55558	1.40256	7.52758
AWPB_IX	3.756	.000	7.95110	2.11693	3.78344	12.11876
AWPB_IIPB	4.763	.000	6.71941	1.41066	3.94222	9.49661
Maslach_1	2.807	.005	3.16087	1.12621	.94422	5.37751

Table 2. Assessment of the statistical significance of differences before and after Balint group sessions

These indicators showed a statistically significant decrease after the Balint groups, which proves the effectiveness of Balint group sessions in reduction of symptoms of professional burnout. It should be noted that the consciousness of reduced stress and symptoms of professional burnout lagged behind the actual reduction of these symptoms – in a number of cases, when providing feedback, group members stated quite aggressively that participation in a group was a waste of time and brought them no benefit.

To obtain more objective data, we divided the sample by age and professional affiliation of the subjects. The division according to the criterion of work experience showed similar tendencies, which, however, were not as pronounced on account of errors (the work experience in a psychiatric clinic or in medicine in general was taken into account). Therefore, the age of the subjects was chosen as a more objective and unambiguous criterion for division into groups.

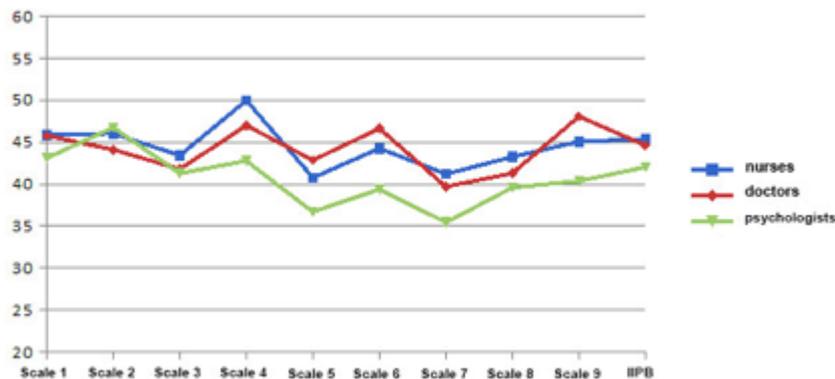


Figure 2. Differences in the level of professional burnout (AWPB) for different specialties

	1	2	3	4	5	6	7	8	9	IIPB
Nurses	45.9	46	43.4	50	40.8	44.3	41.2	43.2	45.1	45.4
Doctors	45.8	44.1	41.8	47	42.8	46.6	39.7	41.3	48.1	44.6
Psychologists	43.1	46.7	41.3	42.8	36.7	39.4	35.4	39.6	40.4	42

Table 3. Differences in the level of professional burnout (AWPB) for different specialties

The findings suggest that there are significant differences in the development of professional burnout, depending on the professional affiliation of the subjects. Thus, scale 4 (professional perfectionism), shows significant difference between psychologists and doctors and nurses, while scale 6 (help and psychological support from colleagues), shows a difference between psychologists and doctors.

We see here that the level of professional burnout in psychologists is generally lower than in doctors and nurses at psychiatric clinics. This can be due to the fact that in the course of their professional training as well as practice psychologists are provided with coping techniques

against professional burnout and self-regulation methods which they can successfully apply in their work. There can be another explanation: clinical psychologists spend less time in direct contact with psychiatric patients, which leads results in lower levels of professional burnout.

There are also differences in the effect of Balint groups depending on the age of the subjects. The best results were achieved in the group of subjects aged under 30.

	1	2	3	4	5	6	7	8	9	IIPB
Before BG Sessions	48,8	45	44	51.7	45.4	44.1	39.9	47.3	50	47.2
After BG Sessions	37.9	32,4	32.9	44.9	35.5	41.2	30.7	36.9	34.7	36,8

Table 4. Assessment of the level of professional burnout (AWPB) before and after Balint group sessions (participants aged under 30)

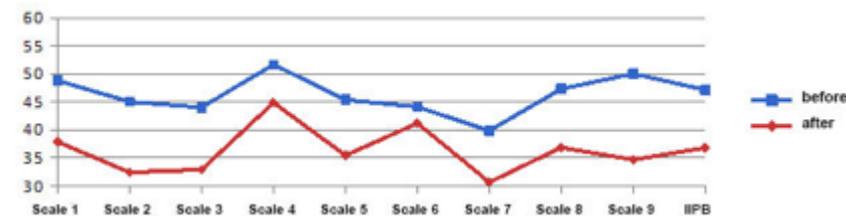


Figure 3. Assessment of the level of professional burnout (AWPB) before and after Balint group sessions (participants aged under 30)

We can see here that the under 30 age group, after participation in Balint group sessions, shows significant improvement in all indicators except for the scale 6 (help and psychological support from colleagues) and scale 7 (professional development and self-improvement).

	t-value of equality of means					
	t	2-sided significance	Difference of means	Standard error of the mean	95% confidence interval of the difference of means	
Lower limit					Upper limit	
AWPB_I	2.751	.009	10.92202	3.96984	2.87080	18.97323
AWPB_II	2.984	.005	12.61538	4.22809	4.04043	21.19034
AWPB_III	2.358	.024	11.09930	4.70707	1.55292	20.64568
AWPB_IV	2.105	.042	6.81259	3.23571	.25027	13.37491
AWPB_V	2.133	.040	9.90769	4.64558	.48603	19.32936
AWPB_VIII	2.530	.016	10.44615	4.12925	2.07165	18.82065
AWPB_IX	3.052	.004	15.35105	5.02913	5.15150	25.55060
AWPB_IIPB	3.100	.004	10.35418	3.33963	3.58110	17.12727

Table 5. Assessment of the statistical significance of differences before and after Balint

group sessions (participants aged under 30)

For other age categories, the differences are not as significant (see Tables 6, 7 and Figures 4, 5)

	1	2	3	4	5	6	7	8	9	IIPB
Before BG Sessions	50.8	52.8	46.3	51.4	44.9	45.4	41.7	44.8	49.3	49.1
After BG Sessions	42.4	42.9	43.2	44.7	37.6	45.4	40.2	40.4	42.2	42.5

Table 6. Assessment of the level of professional burnout (AWPB) before and after Balint group sessions (participants aged 30-50)

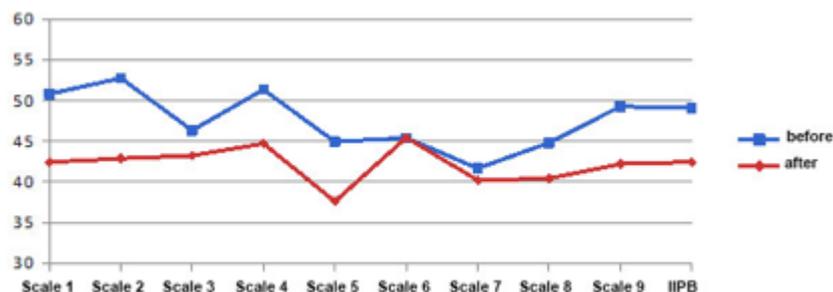


Figure 4. Assessment of the level of professional burnout (AWPB) before and after Balint group sessions (participants aged 30-50)

	1	2	3	4	5	6	7	8	9	IIPB
Before BG Sessions	47.7	48.8	40.1	53.4	41.3	42.5	41.5	42.7	50.1	46.9
After BG Sessions	41.5	40.3	40.5	45.8	40.5	43.2	40.7	41.8	44.8	42.1

Table 7. Assessment of the level of professional burnout (AWPB) before and after Balint group sessions (participants aged over 50)

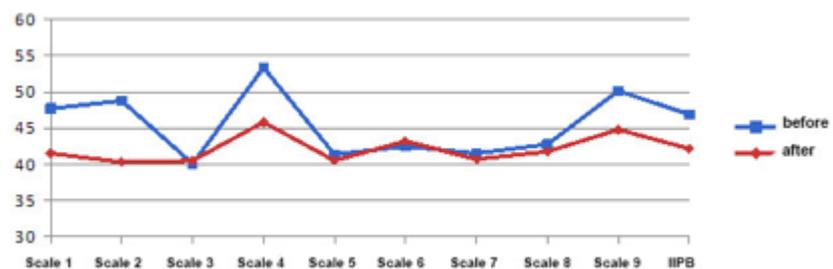


Figure 5. Assessment of the level of professional burnout (AWPB) before and after Balint group sessions (participants aged over 50)

According to the obtained results, nurses under the age of 30 are the most susceptible to the positive effects of Balint group sessions. This may be due to the fact that at this age (and with less professional experience) professional burnout is less advanced, which allows an easier way

out of this pathological state. It can also be noted that the mobility of psychological mechanisms and learning ability decreases with age, which also affects the effectiveness of the Balint groups sessions for older nurses. The latter may require longer participation in group sessions to feel their effects.

We consider the results obtained to be important, as at a young age professional stress may prompt the nurses to quit their profession and change their filed of activities; however, participation in Balint groups sessions can help young nurses solve this problem and remain in the profession.

To verify and correct the results obtained through the AWPB test, we used the Maslach Burnout Inventory questionnaire (MBI), created in 1986 by Maslach and Jackson, adapted in Russia by N. Vodopyanova and E. Starchenkova and supplemented with Bekhterev Psychoneurological Institute's mathematical model. The technique involves the assessment of professional burnout on three scales: emotional exhaustion, depersonalization, and decrease in professional achievements, which correspond to the model of professional burnout, in which these features "manifest in stages."

Assessment of the level of professional burnout is performed in accordance with the following standards:

Subscale	Low level	Medium level	High level
Emotional exhaustion (average - 19,73)	0-15	16-24	25 and more
Depersonalization (average - 7,78)	0-5	6-10	11 and more
Decrease in professionalism (average - 32,93)	37 and more	31-36	30 and less

Table 8. Assessment of burnout levels (Maslach questionnaire)

All the results obtained in our study lie within average.

	Emotional exhaustion	Depersonalization	Decrease in professionalism
Before BG Sessions	19,6	8,52	33,5
After BG Sessions	16,4	7,43	32,9

Table 9. Assessment of burnout levels (Maslach questionnaire) before and after Balint group sessions

This is also reflected in the diagram in Figure 6:

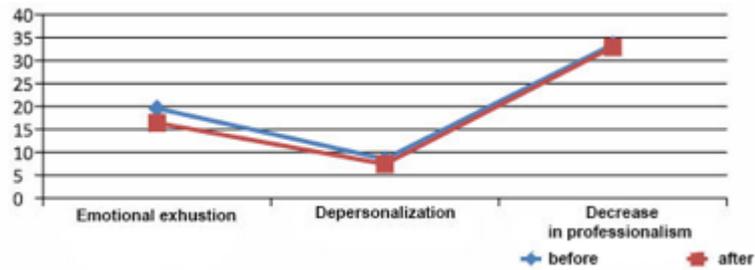


Figure 6. Assessment of burnout levels (Maslach questionnaire) before and after Balint group sessions

A statistically significant difference (t-value) after Balint group sessions was obtained for the emotional exhaustion scale (see Table 2), which points to a decrease in emotional exhaustion after Balint group sessions. However, no change was noted in the depersonalization and decrease in professionalism, due to the fact that these two parameters manifest themselves in stages.

Also, according to the results of the Maslach questionnaire, there was a weak positive age-related correlation ($R = 0.097$) and negative gender-related one ($R = -0.097$) for emotional burnout, which was more frequent in women. For the decrease in professionalism, a predictably weak work experience-related negative correlation was found ($R = -0.109$); however, the correlation was not age-related.

Thus, the data obtained through the Maslach method, which assesses professional burnout according to more general and classical parameters, also confirms the effectiveness of the Balint groups in the reduction of emotional burnout. The reported lack of significant drop in depersonalization and reduction of professional skills suggest that, in general, the difference in work experience prevents the group participants from manifesting the changes associated with professional burnout in a more consistent manner.

Conclusion

The following conclusions were made based on the study:

Doctors, medical psychologists and nurses working in psychiatric clinics are subject to professional burnout.

There are significant differences in the development and course of professional burnout between these three groups, which are also age-related. Balint groups help to reduce professional burnout and yield good results in improving professional communication and professional well-being of specialists.

Balint groups have different effects on specialists, depending on their age and professional affiliation, which indicates the need for a customized approach for each of the groups.

Thus, we can state that the Balint groups are useful primarily in their classic version - as a long-term project designed to overcome professional burnout and increase the communicative competence of doctors and nurses. Our study proves their effectiveness, demonstrated through improved indicators of professional burnout. However, the age and professional characteristics of doctors and nurses should be taken into account when conducting Balint group sessions. Based on our research, psychiatric nurses under the age of 30 showed the best results, which may be due to their better age-related susceptibility to the positive effects of Balint group sessions as well as the fact that at this age (and with less professional experience) professional burnout is less advanced in general.

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Testing Balint Boundaries – When the doctor’s feelings don’t fit well in a single case.

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Abstract

The doctor-patient relationship is an intrinsic part of the medical art. Through my eyes, and my ears, and my touch, I can do medical diagnostics, but my senses are only a sort of passage for empathy.

From a report of a Balint session “without a case”, the author begins a reflection with the group about doubts, fear and uncertainty in medicine, the role of Balint groups in breaking the doctor’s silences, in the presenter’s release from his inner pain and suffering, and finally considering Balint as a practice to bethink the doctoring along life.

Introduction

When we are thinking in the advantages of Balint groups, in our professional life, we get more good sensations than scientific evidence. I remember that young doctors, and even older doctors, often ask us about what have we profited from Balint.

A lot of research, over time, has tried to identify its benefits, but I think that one of the good things we can acquire in Balint, although scarcely spoken, is the possibility that this practice can contribute to a periodic re-discovering of new professional motivations.

The doctor-patient relationship is an intrinsic part of the medical art. It allows us to understand the patient as a whole, one and indivisible person. But inevitably it leads us to look within ourselves. Indeed, when we are in front of a patient, seeing him, listening to him, we are really trying to understand him, but we are also watching into ourselves, being the patient as a mirror where we can observe ourselves. Through my eyes, and my ears, and my touch, I can do medical diagnostics, but my senses are only a sort of passage for empathy. Like de windows of José Tolentino de Mendonça: *“through them we realize that what first seemed to us only a sensory perception of what is outside, was after all a precious prove for us to travel inwardly”*¹.

Balint provides us with more empathy and can improve the empathetic listening of our patients. Their narratives of life, the history of their sufferings, seen with this new ability, with these new eyes, given to us by the group, improves our ability to analyze not only the patients but also ourselves, in the diachrony of our past time and in the synchrony of our present. We discover our own humanity and the fragility of this humanity. As doctors, Balint can make us better observers of life, of time, of the world and, in certain life situations, it promotes the re-discovery of new motivations in our professional life.

Our experience as leaders also gave us unannounced situations that conducts us to think about the limits of doctoring and about what is the objective and boundaries of a Balint group.

I would like to tell you a narrative of a colleague in a group by the end of 2018. And the title for this presentation could be “I’m afraid”.

A non-case – “I’m afraid”

Let me tell you this case. Or non-case.

It was a cloudy and rainy evening of autumn. In Portugal, after the generally hot summers, the first autumn rains arrive in the end of September or October and then the clouds and the wind begin to be part of our daily life. In that day, all the eleven members of our group were present. When I asked, as usual, “Who has a case?”, a general practitioner proposed to talk about a personal situation that was very worrying to him, he said. And he would like very much to talk about that. And almost immediately he shot: **“I’m afraid”**.

Exactly, my dear colleagues: I’m afraid, were his own words. And he wasn’t referring to the rain and wind outside.

Let me tell you that this doctor is a very experienced doctor, with perhaps 30 years of practice. And the astonished group heard from him that he was afraid.

He said: *“In recent time, and when nothing made predict it, because day after day I’m a more and more experienced doctor, I have been worried because of my fear of making mistakes and harming my patients”*.

As I was the leader, I asked if he didn’t want to present a case, a concrete situation where he could eventually have made a mistake or could make him fear of having done a mistake, and present it to the group. But our colleague answered that *“there is not a concrete situation, but it is a feeling that increases day after day, a fear of making mistakes that I don’t know where it comes from”*. It was, probably, a set of emotions built on many different cases, which, added up, could provoke this emotional state.

I thought that this case couldn't be a true Balint case, but a matter of psychotherapy. And I became doubtful. It was a key moment for me and a stressful instant: accept or not accept?

But the group has the wisdom, and I enquired the group about what they were thinking regarding "this case without a concrete case".

All people were silent and astonished, and finally they accepted very well this "case". Curiosity and excitement about the unknown were evident. Perhaps they were also seeing inside themselves.

Only some questions were set up to the presenter. A colleague insisted asking him if this feeling could be objectified in a concrete clinical situation, and he repeated: "no, I've no case to tell you, it's a feeling that increases in recent time". They ask him if he was tired, and he answered: *"no, not more tired than at other times, and at those times I did not have these kind of reaction"*.

So, the presenter went to the pushback and the discussion begun.

Thinking

The discussion was intensive and the group have approached a lot of themes, like the professional tiredness, the discouragement, the burn out, the verbal and non-verbal languages and the importance of the non-spoken language in medical consultation, the attention focuses in consultation, the priority to the patient, the uncertainty in medicine, and some more themes that I don't remember now.

An important moment was when a doctor in the group (who knew very well the presenter), told us that this doctor is a very interested professional, with many patients, really with a very extensive list of patients. And at the same time, he was the director of his health unit and he was too busy and, by the time, it could be difficult for him to manage all the tasks he was supposed to manage. The scope and the comprehensiveness of the profession, not only as a general practitioner but also as director of his health unit could have led him to forget some things concerning his patients, certainly without great practical impact but, as he lived these moments several times, made him create these feelings. Nowadays, patients are very exigent and they ask us for a lot of things. In a profession so extensive and inclusive that needs a wider perspective of the problems, it is not difficult to forget something and, eventually, to make mistakes. And the question appeared: was it possible that in the doctor's subconscious mind these various small errors were tormenting him and sustain doubt and fear?

It is possible that, in his various functions, the doctor have moved his attention from the relationship with his patients to the management of the organization and to the benchmarking tools. We know that the focus of our attention and concern affects our emotion and actions. Could this deviation of his focus of attention have caused the fear of error and the doubts? In

this case, could this situation be dangerous, be "corrosive" to the self (corrosive was the word applied in the discussion), be destructive of the professional self? Could the doctor enter in a depressive deviation because of that?

Or, on the contrary, were these doubts alike those of Socrates in Athens? Healthy doubts, a constructive criticism, the doubts of a wise man. Where was the difference? How to distinguish them? Only by the doctor's feelings?

Being family doctor includes answering to the 6 core competences defined in the WONCA tree: the person-centered care, the community orientation, the specific problems solving skills, the comprehensive approach, the primary care management and the holistic modeling². They have their support not only in the doctor's scientific and technical knowledge, but also in the community context of the professional practice and in his personal attitude towards his patients and his own profession.

At this time, we can also see, that being a doctor requires to have a technical support and a personal support. The doctor needs a reflexive practice as a professional and as a person and both these characteristics have to be emphasized in his practice and in his continuous learning.

Could Balint groups have a role in this support? Could Balint groups be able to help doctors in redefining and recreating the profession, even after 30 years of practice? Watch the past, study and understand the present (the society, the patient needs, the new scientific skills, the empathic attitude) are they attitudes that can be developed in Balint groups?

And what to say about the uncertainty in medicine? We know that our knowledge and our practices are sometimes poor and in constant changes to become more effective, and we are very concerned about passing on this information in a transparent form and in a correct way to the patients. Even if the disturb is not a dangerous disease, it is because of the patient is not feeling well that he is questioning the doctor. Our answers are sometimes not quite satisfactory for the patients. The medicine is becoming more and more scientific, but patient is not. Often we are not successful in explaining this uncertainty and the patients may think that we are not good doctors, and when we think that our patients are seeing us like that, we become more vulnerable, and it is possible that we create doubts about ourselves and fear.

Conclusion

So, the question, again: could Balint group be a support in this state of mind?

Clearly, my group answered yes. Even the youngest members understood that along the time fear will be present, sometimes stronger, sometimes not so far, being the expression of severity of the doctor's doubts. This mental state should not be silenced. The doctor's silence, hiding his own fears, is psychological self-aggressiveness. Silence may seem quietness,

superficially, but it doesn't tell us the truth³. So, because of that, the silence of the doctor can be destructive, or corrosive, as someone said in the group. The Balint group is a great place to discuss and to be conscious of the doubts. Fear is, perhaps, not-conscious doubt. In Balint, we share with our colleagues, as professionals, our private thoughts, feelings and emotions. We can see the hypothetical dissonance between our perspective and the reality. The doubts, the fears, the feelings, expressed in Balint can liberate the presenter from his intimate pain and suffering, and with him, all the members of the group. And to remake his story.

But one question is not yet answered, an issue already posed by Salinsky in 2003: "it is so good, why isn't everyone doing it?"⁴

And why?

*Why don't you speak your silence,
doctor?*

Why haven't you an instant

to share your silence with mine?

You could tell us your fear, your angry,

your joyfulness too

and together walk to find again

our land, our memory,

our mother,

in the silence of peaceful words.

Balint groups can be a sort of tool that allows the doctor to watch his past, to stop in the time to bethink, to observe how his practice mirrors his own personality. Balint is a practice to think the doctoring⁵, where doctors believe they can talk to other people, colleagues, opened to listen to his words, and finally calm the anxiety and the distress⁶. It is a sort of self-directed learning and reflexive practice that is intrinsic to Family Medicine specialty.

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Think Fresh - Is This Still Balint?

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Abstract

Starting point is a set of questions referring to changes since Michael Balint began to investigate how general practitioners dealt with „difficult“ patients. Historical development of psychoanalysis and how it corresponds to the Balint method with its psychodynamic background is reflected.

Various positions show where the Balint method follows a psychodynamic tradition and where the seed of innovation had been planted by Michael Balint as an essential of his research.

The question: "Does Balint work need a theory?" is discussed.

Innovation is illustrated with examples. The attempt is shown how it can be achieved to keep up the tradition of Balint work, and to be innovative by integrating new techniques into Balint groups at the same time. Innovation should serve the initial goal of understanding the doctor patient relationship and stay within the frame, which modern psychodynamic theories keep creating.

Innovation Meets Tradition

During the past 20 years there have been quite a few attempts to introduce new features into the original model of Balint work. What Michael Balint started in the 1950s as a research project and as a model for training family doctors in dealing with "difficult patients"¹ is not the same in 2019.

Whatever we are doing in Balint groups in 2019 - is it still "Balint"?

The answer to this question is YES and NO at the same time.

Since the first fishbowl-session - an innovation introduced by Michael Balint himself at a conference in Sils Maria/Switzerland - what else has been implemented into Balint work?

And furthermore: What happened since 1969, when Michael Balint published "*The structure of the training-cum-research-seminars. Its implications for medicine*"² in the Journal of the Royal College of General Practitioners, a summary of his work with "training-cum-research" seminars to this point one year before his death?

Examples for innovation:

Practically: fishbowl-sessions, working with and without co-leaders, psychodrama, role-play, imagery, music therapy, systemic sculpture, having participate psychologists, nurses, priests, consultants, teachers and social workers (none of these were present in the original setting of any group led by Michael Balint)...

Formally: non-participating observers for research, non-participating interpreters in international groups, evaluation sheets, didactic outlines to train Balint group leaders, compulsory participation of interns according to legal regulations (e.g. Germany), cooperation between psychoanalysts and behaviourists in leadership training, groups meeting informally in a public park of Isfahan/Iran with the secret service around...

Technically: video recording of groups for training leaders, online groups in areas with long distances between participants...

Now, is all this still compatible with the original ideas of Michael and Enid Balint? How would they comment our everyday Balint practice today? Is there such a thing as "the original" or "pure" Balint work? What is to be defined as an aberration of the original and what isn't? Do we need theory as a model for explanation?

So, again the question: what are we *really* doing in our groups all over the globe? And: Is this still "Balint"?

6 Reasons for the Answer "NO"

1. Training and Research

Our Balint sessions nowadays definitely *cannot* be clone-like reproductions of the "training cum research groups in relationship", as they had been initiated by Michael Balint himself. There is a lot more *training* than *research* nowadays.

2. Who can be Group Leader?

Michael Balint himself pointed out that nobody else but a psychoanalyst would be

capable of leading such a group. But some of the first ones to follow him in Balint group leadership after his death were not psychoanalysts but experienced group members, mainly general practitioners, emerging from his first groups.³ Enid Balint did not object to this.

3. The Leader and his Individuality

Every group leader carries his own individual style into the group, not only by what he says but by his attitude which he communicates non-verbally. In this respect there are as many styles of leading a Balint group as there are leaders.

4. Work in Progress

The Balint method has been - and still is - in its essentials a *psychodynamic method*. Exactly this is the reason why the Balint method is subject to a process of change. It changes to the same extent to which the psychodynamic theory has changed over the years. Psychodynamic theory and practice of present times cannot be set equal to the theory and practice of those days in the fifties and sixties of the last century. Psychodynamic theory and practice still is *work in progress*.⁴

5. Object Relation Theory and Group Dynamics

We all should keep in mind that Michael Balint did far more than develop the ingenious method we today know as "Balint group". It was him who contributed a great deal to the changes in theory that has been introduced into psychoanalysis since the days of Sigmund Freud. Michael Balint essentially contributed to the *object relations theory and psychoanalytic group theory*.⁵ Psychoanalysis was no longer a monadic but a dyadic theory.

As a consequence Michael Balint rather focused on the relationship and the dynamics in his groups than on the analysis of the psychological dynamics within the patient.

6. Tradition meets innovation: This caused quite a bit of uneasiness amongst psychoanalysts favoring more traditional Freudian points of view. Nevertheless he kept developing the theoretical positions, that his teacher Ferenczi had introduced⁶, and transformed them into practical experiments. Ferenczi's and Balint's opponents in the British Psychoanalytic Society favored tradition. For quite some time they tried to ban innovation by devaluating them personally in favor of the „pure doctrine“. But time found out what would be conclusive and useful later on, and Michael Balint - the protagonist for innovation - even became their President for some time.

To repeat my question: Is this still "Balint?"

8 reasons for the answer "YES":

1. Openness

To experiment with new ideas is the implicit meaning of Balint's encouragement to "*think fresh*". Fresh thinking, free association⁷, doesn't go along too well with rigid rules. When I do trainings for Balint group leaders I often hear the request for rules. Of course there are some - but not many. There is no need to discuss rules here. Every session of a Balint group is unique. In the end the one to evaluate the session, the group's ideas and the leader's performance is the presenter. In my experience it is often the intervention beyond "the rule", which emerged from an implicit understanding of the unconscious process in the group, and which facilitated the understanding of the doctor-patient relationship.

2. Research

Michael Balint called his project „training cum research in relationship“. What else should be the outcome of good research but something NEW? To give an example: From time to time the group members tend to talk *about* the patient or *about* the doctor. Then we suggest "to get into the patients (or the doctor's) shoes". What is the intention here? My answer: We try to improve the *mentalization process*, the change of perspective as a play. It is a technique we today would attribute to "mentalization based therapy"⁸. To bring these two ideas together and see that there is common ground: that is research, too! Thus we not only do know *how* we do it, but *why* we do it.

3. The courage to stick to one's own stupidity

Michael Balint claimed for each doctor participating in the "training cum research in relationship" to have "*the courage of his own stupidity*"⁹ and to overcome the traditional *teacher-pupil relationship*¹⁰. The idea that the teacher is the specialist with superior knowledge, whom the pupil, knowing less, has to follow, was abandoned. With expertise equal to all the others in the group the leader might learn from the participants as much as they learn from him. So for everyone in the group there is always a good reason to keep asking "stupid questions".

4. The apostolic function¹¹

As pointed out before: During the past decades psychodynamic theory experienced severe changes in its basic assumptions. The primacy of conflict-centered therapy has opened up to new ideas. We increasingly do structural diagnostics and treat according to the patient's structural deficits or structural vulnerability rather than interpreting his unconscious conflict. This is a basic change in techniques of treatment. Psychodynamic research creates new types of interventions. Why should we exclude ideas that help patients (and their therapists!) in psychotherapy from Balint work? Because we know, what is the right way and which one is wrong? Or should the effort of "keeping up the tradition" be the *apostolic function* of the Balint *group leader* in a new dress?

5. More critical scrutiny - less respect

Michael Balint allowed the thought, that a group leader might make mistakes. Furthermore he entitled the group to criticize the leader and expected the leader to cope with that: "*The research-cum-training method aims at establishing equality, among the members of the research team and thus encourages critical scrutiny instead of respect. The price for it is the acceptance by the doctor of an increased responsibility*".¹²

6. The overall diagnosis¹³

Regularly I have children's psychiatrists in one of my groups. They *always* present families and a group of helpers interacting, never a single patient. They present a *system of relationships*, not a two-person relationship. In these cases the systemic sculpture technique¹⁴ helps to illustrate the system of relationships to the group in an iconic way. You just *see with one glimpse of the eye* the net of relationships that the patient presented to his doctor, a net in which both might have been captured.¹⁵ Sculpture work transports a genuine request of Michael Balint: to come to a deeper level of diagnosis, an "*overall diagnosis*"¹⁶ including the social implications that offer the context in which the doctor patient relationship is taking place.

7. The basic fault¹⁷ - Structural deficits of the patient define the relationship

Hundreds of group sessions taught me, that the majority of cases presented tell stories of patients with structural deficits in their personality organization. The majority of these patients seem to prefer appearing in the basic care of family medicine rather than in specialized psychotherapy, if they don't end up in somatic hospital wards for extensive diagnostics. Why that? The reason is simple: These patients externalize their unconscious conflict into their personal relationships, but they are unable to see their own individual contribution to the problem. They generate neurotic or psychosomatic symptoms, and by "*offering their symptom*" they establish their problem as a *scene with their family doctor*, who has a hard time working with them, if he does not understand, *that the patient is re-enacting his "basic fault" in the doctor-patient-relationship*.

8. The flash phenomenon¹⁸ - emergence of the implicit

Once the basic fault has intruded into the doctor-patient-relationship the doctor starts to struggle with processes of transference and countertransference. This usually takes place on a non-verbal level. The doctor reports the trouble to his Balint group. But in the Balint group these cases often lead to helplessness and speechlessness among the group members. The group atmosphere turns to be sticky. Even worse: silence captures the group. If the silence is an expression of the preverbal, *implicit* process presented in the case, the group keeps having a hard time to find words. Or on the contrary: the group members might talk a lot, preferably about what they *think*, not what they *feel*. In both cases we have an unconscious re-enactment of the situation that originally had happened in the doctor's office.

So if the problem is the unspoken, how do we get a hold of the "the implicit of the case"?

I quite often suggest an experiment to the group: I encourage the group members to close their eyes, focus on the images that spontaneously arise from their unconscious, and report them to the group. Very often we now get a description of what the case *implicitly* deposited in their emotional perception. There is a *"process of signs"* beyond the outspoken word between the doctor and the patient. Eugene Gendlin called this "focusing"¹⁹. Using the *"perception of the implicit"*, the *"felt sense"*, the *"thinking at the edge"* helps to focus our perception on these "dialogues without speaking". The patient's disorders were generated very early in his biography, they describe his preverbal emotional condition. Like a baby crying the patient is *acting out* what he feels, and the scene - like a code - has to be deciphered. Winnicott, Mahler, Bowlby, Ainsworth, Stern and others gave us an idea, how mothers decipher their babies' communication. The *perception of the implicit in unconscious images* creates situations where a *"flash phenomenon"* might appear - *within the Balint group*.

In the points I stated you might perceive, that they all have a practical forefront, but at the same time are connected to a theoretical background.

This leads to the question:

Does Balint work need a theory?

Modern medicine acts as if it would not necessarily need a theory. Modern medicine still tries to reduce questions and answers to physical science. The "machine model" of a human being according to René Descartes - who died in 1650 - still is the favourite.²⁰ Michael Balint called these cases the *"Class I cases"*, in which a defined set of "illness plus treatment" can be found. For the *"Class II cases"* there is no theory in modern medicine, and in consequence there is no traditional diagnosis. Instead there is an *"interplay of offers and responses"*, almost always leading to an *"irrelevant agreement"*²¹ between the doctor and the patient on which the treatment is based.

As far as practical routines in leading Balint-groups are concerned, we actually don't need a theory at all. But every once in a while someone favoring the "machine model" puts up the question: what precisely is the explanation of what you are doing? Then indeed it is helpful to have a theoretical model to refer to. Michael Balint definitely had both, practice and theory. And in both he was open to innovation: *"It was found that in our training cum research seminars all these rules and percepts, so important in the analytic practice, had to be re-examined and often fundamentally re-formulated so as to make them meaningful for other forms of medical settings."*²²

Keeping tradition – risking innovation

Balint work is taking place in a defined frame, leaving freedom of thought within. Definitely there should be a story of *a professional and a client* reported to *a group of professionals* to start with. And: The group procedures should relate to essentials of psychodynamic theory and practice.

But still: With every new idea that we introduce as an experiment into Balint work, we should thoroughly balance the reasons for or against it.²³

I told you my favorite examples for innovation in my Balint groups, imagery techniques borrowed from *Focusing* and sculpture work as a method of *Systemic Therapy*.

- These two ideas can be easily identified as capable of dealing with the unconscious of the patient in his social context. They help the group to get access to the *implicit procedural knowledge*²⁴ about the case.
- The corresponding techniques help to put the unspeakable, the *implicit*, into words. They follow a tendency of psychodynamic practice to go beyond the spoken word, using *„the initial scene“* and *„acting out dialogues“* in *„the oscillating field of intersubjectivity“*²⁵. It is exactly there, where a *flash* might appear.

New ideas might question habits that we have become fond of. But taking Balint's approach of *„training cum research in relationship“* and his encouragement to *„think fresh“* seriously, there is no reason to be too sceptical. As long as we keep within the boundaries of the *modern* psychodynamic theory, and - even more important - as long as we keep reflecting what we are doing, in order to understand the doctor patient relationship, I would not hesitate to say:

Yes, all this is Balint!

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Cap. 06

Students, Doctors and Patients

Through the Eyes of Medical Students: Reflections on Suffering and End of Life Care

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Abstract

Medical students are often required to write reflective essays in relation to experience-based learning in their clinical attachments. We used dialogic narrative methods to research five student essays that had been submitted in 2015 to the Balint Society of Australia and New Zealand (BSANZ) reflective writing competition. Students were from Otago University, New Zealand; they wrote about their learning experiences when working as assistant caregivers in rest homes, where some residents were suffering or dying. This paper uses extracts from two

essays to illustrate pre-clinical students' reflections on their experiences of end of life care, as well as some of their emerging insights. We also speculate on why such student essays can be quite poignant and compelling for listeners such as doctors and other health professionals.

Introduction

For the last 43 years, the Foundation of Social Medicine and Psychosomatics has sponsored the Ascona Prize for essays by medical students. And since 2003 in Berlin, prize winners have been invited to present their essays at the biannual Balint Congress, usually to much interest from other participants. There seems to be something quite poignant, even compelling, when a student reads out their essay. Their stories appear to resonate with other health professionals, even if listeners had different training. Aspects of their stories may also be quite troubling in various ways. Perhaps students' stories^{1/2} of their early clinical experiences are similar to case presentations within Balint Groups, where participants are often reminded of challenges in their own clinical relationships.

In addition, students are new to medical practice. Ernst Petzold has edited several collections of Ascona essays and suggests that *"students appear as witnesses or as participants without authority, but this gives them a welcome opportunity for independent judgment."*³ Through their eyes then, perhaps we are experiencing clinical practice as if for the first time; perhaps we are reminded of our own tentative, and at times tremulous journey from layperson to health professional.

In this paper, we focus on students' reflections about patients who were suffering or dying. Such situations may be especially challenging for students,⁴ where they may experience considerable anxiety.⁵ Furthermore, if a doctor is supposed to be helping people, what is their role if the patient is suffering terribly, is beyond medical cure⁶ or is clearly dying?⁷ How might these situations affect the person of the student, who may wish for more agency and effectiveness? No wonder then, that student stories about end of life care⁸ might be especially poignant for us listeners, given that many of us may face similar challenges in our own clinical work.

Rather than being a formal research report, this paper briefly reviews our research over the last two years into medical student writing. We also present extracts from students' essays to illustrate how they make meaning from their observations of end of life care.

Context

In 2015, the Balint Society of Australia and New Zealand (BSANZ) held its first essay writing competition for medical students in those countries. Curated by Alexa Gilbert-Obrart and Hamish Wilson, the format is closely based on the long-standing Ascona Prize³, with the usual

reflective writing requirements of description, analysis and implications (see Appendix). Similar in format to competitions for doctors in the US and UK, the aims are to encourage local medical students to write about their significant interactions with patients and to increase awareness of Balint Society activities. Submitted essays can be based on those already written for their course requirements, but participation is voluntary and separate to their usual training.

Lawrence Gilbert Memorial Prizes (A\$500) are awarded to the two top essayists, and leading essays have been published in relevant medical journals.^{9/10/11} Winners and/or runners-up have also received subsidised attendance at the 2017 and 2018 BSANZ annual workshops, where similar to a Balint Congress, they read their essays to other participants. The essay competition is biannual with 58 essays submitted in 2015, 72 in 2017 and more expected in 2019.

Of the 58 essays in 2015, we selected the 24 rated highest by our judges and approached their authors to use their essays in our research project; 22 students gave consent. We chose to analyse essays that described pre-clinical students' experiences of working in aged care facilities or rest homes. There were five essays, all from Otago Medical School in New Zealand. Since 2008, all students at Otago work for 20 hours as assistant caregivers, providing day to day care for the people or 'residents' who live there.

Our initial research questions focused on what students learn as a result of their rest home placements; how students' characterisations of residents evolved over time; and how students develop their ideas about doctoring as an outcome of their learning. Ethical approval was gained from the Otago Human Ethics Committee. There were three male and two female students, with an average age of 20 years.

All authors are medical practitioners and teachers with experience of qualitative methods of research. HW convenes the programme that places students in rest homes and is also one of the curators of the essay competition.

Using dialogic narrative analysis^{12/13}, we worked on each essay individually, then met (by Zoom) to compare results. Our meetings often produced further perspectives and deeper layers of meaning. This method led to multiple findings: two articles have now been submitted to medical education journals, initial titles being "Junior medical students' reflections on end of life care" and "Identity construction in medical students' stories of caregiving."

Reflections on experience

This discussion paper draws on those articles, focusing on students' observations of suffering or dying, and how their reflections can help them make sense of those significant experiences. We will use extracts from essays by two students, Richard and Sean, to illustrate the style and tone of student writing. Names of students, caregivers and patients have been changed to protect their privacy.

Richard's essay was called "*Lesson Learned.*" Being uncertain what to expect in the rest home, he starts by describing his anticipatory emotions, ranging from excitement to terror. Once in the facility, he observes two sorts of residents. Some were active and engaged in life, but his 'heart went out' to those who were frail and lonely.

Richard provides three detailed narratives, each with carefully chosen headings. In '*Waiting,*' for example, he slowly feeds an elderly dependent woman, gaining more expertise over time. '*Strange noises*' is about his sadness for an isolated old man with breathing problems.

One of my most disturbing moments was during orientation, when we passed a room of a frail old man. He is name was Mr Norton. He was desperately gasping for breath and making strange sounds I had never heard before. No one was with him - no nurse or carer was attending to him. In that moment, I thought that this man was about to die - gasping for his last breaths. Fortunately, he didn't. It turned out, Mr Norton made these noises constantly, it was his attempt at breathing and coughing up the sputum in his lungs. I later helped feed him. The sound of his coughing and straining upset the other residents, so he was fed in his room, alone.

As I got to know him over the week, the thing that struck me most was his eyes. They were still and motionless, fixed on an object far in the distance. Yet, they weren't helpless eyes; rather strong determined eyes (as if he was trying to remember something). I talked to Claire, my supervisor, about Mr Norton. She said he had come to the rest home before she started working there. She often wondered what he would have been like before he had become like this. Who was he? Where did he come from?

What stories and experiences could he have told us? All incompletely answered questions. I asked if Mr Norton had any family. Claire said he only had a son who visited occasionally - she had only seen him two or three times.

As Mr Norton continued to cough and splutter, struggling to swallow, Claire gently stroked his head providing him the only comfort she could. This calmed him - you could tell as his fists unclenched.

It was heartbreaking to see this old man, trapped inside his frail, motionless body. And yet with this sadness came an overwhelming sense of appreciation for Claire and for the care she does every day. What I learnt from her will stay with me for the rest of my career. She is a strong and stubborn lady. Yet, above all else, she is kind and genuine. The way she cared for her residents is how I want to care for my patients. Claire later told me "they are not residents, or friends - they're family".

In Richard's narrative, Mr Norton's personal background is a mystery; he has few visitors. The absence of medical details or doctors is also significant. It is not clear why he is confined to his room; perhaps there are not enough staff or they are inured to his cries for help. He seems

to have considerable suffering, but is unable to express it verbally. Richard is quickly taken out of his knowledge and comfort zone. He seems to feel Mr Norton's suffering and isolation quite directly; unconsciously perhaps, he attempts to put into words what the old man cannot.

Yet despite being so challenged, Richard concludes his essay with the following:

This week has been such a blessing. I think I have stumbled across the most valuable lesson I may ever learn: healthcare = good relationships + a little bit of medicine. Not the other way round. Kind and genuine relationships are always more important than being brilliant scientifically.

We turn now to Sean, who wrote "*A Thousand Visions and Revisions: Developing Interdisciplinary Skills through Reflection.*" Initially, Sean describes several chaotic scenes in the psycho-geriatric ward that he finds very challenging, even overwhelming. For example, an elderly male resident approaches him aggressively; other staff have to come and help. There is a complicated toileting scene where Sean has to do the wiping for an elderly woman, while also at the same time, 'heaving a giant man' out of the room.

In a narrative entitled '*Coming to terms with tragedy,*' he witnesses the suffering and loneliness of a dying man in great pain, despite the efforts of staff who are also affected emotionally. Here is Sean's initial narrative:

Later that night after dealing with the giant man, it became clear that one of the patients was on his last legs. He was completely incontinent and was passing motions frequently. Cleaning his diapers was extremely unpleasant, and his parchment like skin was fragile. I even hurt his foot with my nail when putting on his slippers. He looked so defeated, his eyes glistened with tears and he was in terrible pain. Discussions sprung up among the nurses regarding hospitalisation, but there were no night staff able to take him nor loved ones to look after him. The nurses were feeling the severity of the situation, and I could see a few getting increasingly upset.

It was incredibly tragic; I felt like he was a reject of society, an outcast forgotten by those who loved him and spat out by the people who couldn't understand him. Here he was, sitting in the ward, surrounded by strangers in horrible pain, alienated by his incontinence. To me his howls were like a baby's screams and I felt tears welling up in my eyes. I stayed on for a further hour to talk to him and to finish off the cleaning. I thought of my mum and dad, and swore I would never forget them if they ever became like this.

As noted above, the essay instructions encourage further analysis and implications of the clinical story. Sean continues:

It was in times like this that you realised the fragility of human life and the momentous suffering that people can endure. Carers dealt with it differently, some made jokes and others retreated into themselves, a few jumped into action. Having never known true loss - I retreated. I felt

guilty, because as a future health practitioner I needed to be capable of being proactive in such a situation. But I was so stunned by the weight of his suffering. The most experienced nurse later reassured me that with time it got easier and that you learnt of ways to cope. She told me that death was a part of life and a natural process with its own sense of renewal and honour as it provided the opportunity for newer generations to thrive.

It was a beautiful perspective. I decided that I needed to adopt a similar outlook, although I think it will take me some time to come to terms with death and its inevitability. After my first shift I was asked if I'd be interested in working there, and with a four month holiday looming it will be something I definitely think about.

In this narrative, Sean admits to feeling helpless in relation to such suffering. He also acknowledges other feelings such as fear, blame, and action-anxiety (eg the desire to care effectively for his own parents). He and other staff are emotionally in touch with the sadness and tragedy of a man dying alone in this way; perhaps they have become surrogate relatives. We wondered why there were no doctors involved, as modern palliative care may have provided considerable relief. Sean appears to accept this situation, perhaps not realizing that end of life care can be more effective. Yet despite all these assaults on his senses, Sean considers working there again, perhaps illustrating his growing confidence in providing personal help to such dependent people.

Discussion

Our project extends on previous narrative analysis on reflective essays by Roland Koch and Finn Hjelmblick from Sweden.¹⁴ Their students also wrote about situations where they could not meet their patient's needs, but by using their own inner resources, they turned 'potential trauma' into personal learning.

Similarly, our research offers perspectives on how medical students start to make sense of quite challenging experiences. Their written reflections can help them to formulate ideas about what kind of doctor they see themselves being in the future,¹⁵ even when there were no doctors as role models in that setting. Such useful outcomes may arise in part through the usual essay requirements; initial clinical description is intended to be followed by detailed analysis and personal implications for future practice. For students (and doctors) to make the most of their learning experiences, reflection needs to be in depth.¹⁶ Reflection may then lead to what is known as 'perspectival transformation,' where underlying beliefs and personal constructs are both challenged and changed.^{17/18}

Returning to our question: what is it about these student essays that might be so intriguing for us listeners, especially those outstanding essays that receive awards? What are they seeing that might resonate so readily, or on the other hand, might trigger feelings of regret, disappointment or even shame about patient suffering or standards of clinical care?

As Kenneth Keniston¹⁹ from Yale perceptively observed in 1967, *"those who enter the healing profession may be distinctively motivated to confront actively the issues of suffering, death, and care which most of their fellows anxiously avoid."* Perhaps then, our resonance with student stories is through our compassion for their required bravery, as modern students are now quickly placed in the deep-end of clinical care; avoidance of suffering and dying is no longer an option. Perhaps also our task as clinicians and teachers is to be aware of the enormous challenges in their journey, so we can offer a guiding hand as they undergo the necessary, and at times painful, rites of passage in becoming a health professional.

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Appendix. The BSANZ Medical Student Reflective Essay Competition: Instructions

Reflective essays submitted should describe a student-patient relationship, an experience, or experiences, from within the student's medical studies and include critical reflection on personal meetings with patients. Material already used for course work must be re-worked for submission. Previously published work for medical theses or diplomas should not be submitted. Each essay should include:

Description: A detailed presentation of a personal experience of a student-patient interaction or relationship.

Reflection: Review or reflection on how the student experienced this relationship, either individually or as part of the medical team. Analysis should include the student's own perception of the situation, the challenges faced and how he or she responded.

Implications or 'critical reflection': Discussion about ways in which the student's own approach might change in the future, and/or also possible ways in which medical training might enhance the capacity of students to engage thoughtfully and compassionately in patient care.

Competitions are held every second year, with the closing date usually in May. See: <http://www.balintaustralianewzealand.org/bsanz-writing-prize/>

Recovering the Healing and the Humanity in Medicine: Doctors and Patients in Conversation

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Abstract

The Balint group began as an experiential continuing education seminar in the U.K. and in the almost seventy years since, has evolved into a mainstay of training and practice for primary care physicians around the world. The content has been the depths of participants own experience, made possible by establishment of a safe space and accessed through a structured process by a trained facilitating group leader. The patient's experience is represented only through physicians' speculations. What if a space was created to include physicians and patients who could each present their own story about their experience, the nature of their relationship with their counterparts and have a discussion about maximizing the benefits of the healthcare experience for both of them? This paper describes such a program, reports on four of these facilitated dialogues and discusses the benefits, the similarities, the differences and the complimentary nature of Balint groups and these Third Conversations.

The (U.S.) healthcare system causes deep wounds for both patients and clinicians, although they manifest differently. Patients describe a system that routinely fails to coordinate amongst providers, where errors are too frequent and poor communication causes frustration and gaps in care. Clinicians are burdened by administrative requirements that limit their ability to perform the art and science of medicine; they lack agency, which leads to burnout, depression, and

rising rates of suicide. Yet, both groups are having largely separate conversations about these consequences of the same broken system.

Physicians who participate in Balint groups have the advantage of a Balint Group structure that creates and maintains an emotionally safe group environment. This enables physicians to witness each other's stories and to learn about the interpersonal dynamics of the case. New perspectives seen through others' eyes often lead to new understanding of what is needed in healing relationships.

Patients who participate in support groups for certain diseases or conditions may experience some of these benefits – an emotionally safe space and a process for generating new understanding – but such groups are largely focused on living with disease or disability. We do not know of groups designed to help patients or family caregivers to process trauma that can be inflicted on them by the system during the care process itself.

Further, we know of no structure for helping patients and clinicians come together in a safe space to process their collective experience *together*.

Approximately ten years ago, John Salinsky spoke to the IBF Council at a meeting in Chicago about a hypothetical Balint group, one consisting entirely of patients. The case that would be presented would be about us - yes, a doctor that the patient-presenter could not get off of their mind. What could that doctor have been thinking to account for his behavior? How might we think about that doctor differently the next time we had an appointment? Would we have the voices of our fellow group members in our ear coaching us to be a more empathetic and understanding patient? As you can imagine, we all smiled with some amusement as we pondered Dr. Salinsky's creative way of getting us to consider what might be heard if patients spoke about their doctors, other clinicians, or even their healthcare experience broadly defined.

Whether in curbside consults, morbidity and mortality rounds, support groups or Balint groups, physicians talking with each other about patients can be thought of as '1st Conversations;' it is a dialogical outlet for the occasional, less than satisfactory encounter with a patient. Similarly, groups of patients in a given community or with the commonality of a shared diagnoses, who discuss with each other a recent challenging experience with a doctor can be thought of as '2nd Conversations.'

This begs the question, what if we were able to structure conversations that included both primary care physicians and patients talking *with*, and not about each other? What if we could create a "3rd Conversation?"

An Exploration in Four Communities

With support from the Morris-Singer Foundation, a core team composed of a primary care

physician, two consumer advocates, an expert in narrative and a highly trained group facilitator began a collaboration to create this 3rd Conversation. We designed a group process and created the program architecture for community-based conversations between front line clinicians and patients in their clinic or system. Designed to address the interpersonal impacts of a fragmented and frustrating system, clinicians and patients came together, in person, for an evening to talk about their experiences and the centrality of the clinician-patient relationship as a source of healing.

We knew that this conversation must be carefully constructed given the asymmetry of power and information between clinicians and patients. We sought to create a safe space in which these two groups could come together with authenticity, honesty and equality. We researched early examples of this and related approaches, such as the 2003 Wisconsin Citizens Congress project organized by the Wisconsin Medical Society. We also researched and learned from Balint groups, the Nonviolent Communication model, Citizen Health Care in Minnesota and more. In partnership with the expert facilitator who specializes in high-risk meetings that bring together two communities who often don't have an opportunity to truly "hear" each other, we designed a process heavily reliant on individual narratives and appreciative inquiry. Our goal was to create an "empathy bridge" and to encourage human connection between participants. Our theory of change: building empathy and a sense of shared experience would also create motivation for both patients and clinicians to find ways to improve the system, either individually or collectively.

The emerging 3rd *Conversation (3C)* became a facilitated dialogue in which equal numbers of primary care clinicians, and patients and family caregivers sit knee to knee, break bread and share a meal, and talk about the entanglements of working in the American healthcare system *and* what it is like to receive care under the those same constraints. They are organized locally and "hosted" by at least one patient or family caregiver and one clinician. In these events, participants:

- Hear two stories - one from a patient and one from a clinician - about their experiences with the patient-clinician relationship, and challenges in giving and receiving care. They model vulnerability and openness in front of the group.
- Agree to a set of guidelines designed to support story telling containing emotional vulnerability
- Pair up in dyads (one clinician, one patient or family caregiver) to explore each person's real, lived experiences and relationships in health care.
- Use their experiences and emotions to collectively imagine what health care would look like if the patient-clinician relationship was valued and prioritized.
- Form small groups to share their collective experiences, and then articulate in a

whole group discussion what they feel inspired to do individually and together to create change – in themselves or in the larger context in which they live.

Between May and November, 2018, we conducted pilot 3rd Conversations in four communities: Rockville, MD; Atlanta, GA; South Huntington, MA; and Allentown, PA. with between 15-24 participants and several observers in each one. Participants included patients, physicians, and other clinicians. A debrief with the 3C core design team and the patient and clinician hosts was conducted following each event during which the process was discussed, and next steps and improvements were brainstormed.

Outcomes and Evaluation

For some, the 3C experience itself was therapeutic. Most participants said they were interested in continuing to engage with each other post-event, and all evaluations showed that participants thought the initial 3rd Conversation event was a valuable use of time. A strong majority of both patients and clinicians (at least 70%, typically more than 80%) of all participants reported:

- Increased sense of hope and ability to positively impact the health care system (agency is key to addressing burnout)
- Feeling understood and valued by other participants
- Being better informed about the patient-clinician relationship
- Feeling more connected to other participants
- Being able to be honest about experiences and hopes
- Feeling safe being emotionally vulnerable

Discussion

If we consider the relationship between doctor and patient as a window, we must admit that doctor and patient far too often are looking through it from two different sides. A reframing is needed- we must look through that window using both of these two complementary lenses; however, we must realize it is not an *either/or* proposition, instead, it must be *both/and*. Both perspectives, held shoulder-to-shoulder and side-by-side, can support and inform us about the complexities of doctor-patient relationships. Each process utilizes a different approach, and the outcome paints a picture from a different perspective.

Similarities

There are obvious similarities with the creation and maintenance of a 'container' or space where participants are invited to share personal stories about their experiences. The container is monitored and protected by group leaders who identify guidelines, which help define the boundaries and provide direction for individuals' participation. Group members have chosen to set aside this time for a common purpose, and they attend with an intention to explore the nature of their experience in the healthcare system. Accepting the conditions of the container allows greater emotional safety resulting in sharing stories with greater authenticity and a decrease in personal caution and wariness. It is only in the supportive environment of the container that we access and then share these experiences that have the most meaning.

It is also clear that our emotions, which are imbedded in all of these stories - both positive and negative - are the dynamic energy that gives these stories their life, that forge connections and support healing relationships. The heartfelt stories that are shared create a window into participants' individual experiences. Our stories are often personal and private experiences that are lived and felt viscerally, and many have not been previously shared with others. To now have an audience is often a learning experience for the storyteller herself, who now has the psychological and emotional and health benefit of having put her experience into words. The storyteller no longer has to carry the story alone or carry it internally; in her telling, the story is shared and the burden is lessened or the joy is multiplied.

Balint and 3C are also similar in that each process explores the same 15 minute clinician-patient encounter outside of its usual hierarchical environment and without the typical limited time constraints, while being guided by a particular group architecture and facilitated by a group leader. The invitation is to explore that 15 minute encounter through varying lenses as narrow as a microscope and as wide as a panorama. Further, it is true about both a Balint group and a 3rd Conversation that the description is very different from the experience. The context as described on paper is markedly different than the impact upon participants' internal landscape as experienced in 'real-time.'

Differences

The most obvious difference between Balint groups and 3rd Conversations is the inclusion of patients in these 3C discussions about patient care and clinician-patient relationships. In some ways, groups of physicians meeting to discuss patients, even in the empathetic style of Balint groups, recreates the doctor's office environment. With 3rd Conversations, there may be a greater sense of separation from the doctor's office, encouraging doctors and patients to meet more on equal footing. Doctors and patients are now humans who happen to have specific roles in health care transactions, but who both have their own needs and hopes for the system.

The direct impact of doctors and patients talking with each other is that patients are listened

to and valued by people who they highly respect, and doctors are listened to as humans who are fallible and who have needs and who at times, struggle. The mutuality of their humanity is, in itself, healing. It is also unusual that both physicians and patients are listening to stories told by participants who come from a different level on the hierarchy. How liberating it must be for doctors to share their experiences with patients who are prepared to listen or for patients to be validated by doctors. It is particularly gratifying to speak authentically in an environment usually dominated by hierarchy. We have seen patients bear witness to both the pain and the promise in physicians' stories. Clinicians also learn a lot about what patients really want and need, and it is often surprising how aligned both are.

The use of the appreciative inquiry approach highlights, in particular, those aspects of the relationship and the system that meet both physician and patient needs. Although stories about excellent encounters and relationships are not excluded in Balint, our tendencies are to tell the stories about interruptions or interferences in relationship building. These are two different approaches to improvement. For one, a focus on what is working helps participants imagine and be inspired by ways to build on those strengths. For the other, deeper exploration on dynamics may reveal biases or blind spots, which can then inform Balint group members about their own personal explorations.

The differing nature of the commitment that group members make in these two processes result in differing nature of the result. Members of Balint groups make a commitment in advance to participate in their group on a regular basis. As in any group, regular meetings designed to facilitate the sharing of intimate personal stories among a consistent group membership supports the development of deeper trust and stronger emotional connections among group members which allow even more personal explorations of understanding self and other. 3rd Conversation pilots requested only a one-time three-hour commitment of time. Their primary focus was ensuring a safe conversation space.

Because Balint groups meet typically for only one hour and spend the entire time on one story, and they do this in such a high trust environment with a consistent group membership, the group's discussion can proceed into much more depth. In marked contrast, the 3rd Conversation process elicits many more stories with all participants free to share what is most meaningful. While 3rd Conversation partners are guided in an active listening process, any learnings are more a reflection of a 'here and now' didactic process rather than the more inductive, analytical perspective a Balint Group discussion provides. For 3rd Conversations learning, the group's facilitator elicits from the group learnings, observations, and potential to support similar discussions in the future. 3rd Conversations organizers have provided a members-only online community for participants to continue to communicate and plan together for any future events.

In summary, it can be instructive to examine the doctor-patient relationship through different windows to more fully experience different perspectives. Through 3rd Conversations, physicians more explicitly consider their own unmet personal needs in their participation in health care systems. This is in addition to the physician's professional needs. Patients have the unusual

experience to witness and understand physician's perspectives, enabling them to contribute to establishing physician-patient partnerships between two humans, not just between a doctor and a patient. Instead of only asking "What does this patient need from his physician?" Balint Group leaders might consider asking: What might it be like if we also took time now and then to celebrate the patients with whom we are truly providing healing experiences? And to explore the conditions that are present in these times so that we may create more of them in the future? Is this also an important part of healing and processing the emotional impact of being a doctor? Even one 3rd Conversation might clue physicians into the range of needs expressed by patients and clue patients into the human side of their physicians. Several of these conversations might open up more windows in an entire community to the healing possibilities of healthcare partnerships both inside and outside of the examination room.

These two different processes have two distinctly different histories - Balint groups' origin is in the early 1950's and 3C is in its infancy. However, they share overlapping goals and similar intent to use the power of intimate conversations to strengthen doctor-patient relationships. We are eager to hear your reactions, your observations and your questions about these 3rd Conversations.

Cap. 07
Different Views

The Balint Group Seen Through the Pharmacologist's Eyes

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Abstract

Michael Balint introduced us to the doctor as the drug . In this paper using "the courage of my own stupidity" I ask whether a Balint group can also be likened to any drug prescribed today. Looking through the pharmacologist's eyes we shall look at the structure, composition and dosage and strength of the drug followed by mechanism of action and ending with side effects and allergies. Using a mixture of literature references and a dash of my own insights from my personal "addiction" to Balint groups I shall try and make the case that Balint's groups themselves can indeed be seen as a form of medication useful to today's busy caregiver.

The Balint Group Seen Through the Pharmacologist's Eyes

Hello. My name is Mark and I am addicted to Balint. Interestingly I first realized I was addicted in Portugal at the opening ceremony of the congress in Lisbon in 2007. I clearly recall Jorge Brando describing his addiction to international Balint work, all this to a background of wonderful guitar music, "I want more of this " was my clear feeling then and now.

This analogy offers as an invitation to explore the common ground between participation in a Balint group and a drug.

In his landmark book the Doctor, His patient and the Illness, Michael Balint introduces us to the concept of "The doctor as a drug". One of the doctors who attended what was then called "the seminar" (not the group) Philip Hopkins wrote "By far the most frequently used drug in general practice was the doctor himself".

Michael Balint warns us that he makes no references to the medical literature and all the observations made were based on "the courage of our own stupidity".

So it is in this light that I shall present to you a combination of literature quotes and a huge dash of the courage of my own stupidity.

In the opening paragraph of the introduction Balint writes and I quote "It was not only the box of medicine or the bottle of pills that mattered, but the way the doctor gave them to his patient- in fact the whole atmosphere in which the drug was given and taken." He continues "No pharmacology of this important drug exists. No guidance is contained in any text book as to the dosage in which the doctor should prescribe himself, in what form, how frequently, and so on". He also alludes to the lack of literature about possible allergies and side effects. He saw that one of the chief aims of the seminar was to "start devising this new pharmacology".

Is it possible to see a Balint Group in this context as a drug as well? In order to answer that question I thought we could draw up a drug information sheet as is common for every prescription drug on the market today. But before we proceed we need a name!

One of the things I most enjoyed about preparing this presentation was choosing a commercial name for our generic "Balint Group". This was an opportunity for me to get my revenge on scientists who develop and drug companies that market the hundreds of drugs I use in my clinical practice. Have you noticed how they go out of their way to find names that you have great difficulty remembering?

A recent example is a new class of drugs to lower cholesterol. Can anyone tell me what PCSK9 stands for?

It is a Proprotein convertase subtilisin/kexin type 9 inhibitor with the generic name Alirocumab and marketed as Praluent.

In Israel Teva pharmaceuticals have come around and introduced a drug called Torid(Drop in Hebrew) for high Cholesterol and Tarim(Raise in Hebrew) for erectile dysfunction.

So in this spirit it is my privilege and honor to give you

EMBRACINE which with ongoing groups is called EMBRACINE FORTE and sometimes at congresses EMBRACINE PLUS or as it is called in Germany a groise groep with all congress participants involved.

So why Embracine? Those of you unfamiliar to Balint meetings may have noticed that Balint friends often greet each other with an embrace or hug. In a moment we shall look at the structure of a group which is almost circular just like one's arms in an embrace.

During group work we all embrace the case presented extending a hug to the presenter even if he or she is outside the circle. And in ongoing groups members are constantly supporting each other in a metaphorical hug.

So where do we go when we want to find out about a new drug? There are many on line websites such as Micromedex and Dynamed. But no matter which you choose when you insert EMBRACINE it comes up blank.

In a wonderful article entitled "The Root of physician burnout" which was published in the non medical The Atlantic, Richard Gunderman writes: "To enhance fulfillment and quality of work, it is necessary to focus on the work itself. If we are genuinely concerned about physician burnout, we need to focus less on reducing stress and more on promoting what is best in physicians: compassion, courage, and above all, wisdom. He continues "Burnout is not a disease. It is a symptom. To combat it, we must focus primarily on what underlies it. And here the key is not eradicating the disease but promoting professional wholeness, which flows from a full understanding of the real sources of fulfillment".

I believe that through our work in Balint groups we concentrate on what made us decide to chose a caring profession- our wish to make a connection with fellow human beings in distress and help alleviate their suffering. In Balint groups we concentrate on our relationships with people hopefully making us more fulfilled professionally.

With that in mind let's move on to do our drug information sheet and we shall start with the molecular structure.

As mentioned earlier the groups are usually circular and comprise about 6-12 individual participants that are in a constant interaction between each other. Usually this process is led by two leaders whose function is to maintain and protect this environment. One participant starts the process by presenting a doctor-patient case following which, to quote a 2015 article from the British Journal of Psychotherapy, the other members "metabolize the doctor patient relationship". Mills and Smith write "This opportunity to explore feelings and experiences offers a way for doctors to metabolize and understand emotional states triggered by patients. It is proposed that this not only helps prevent 'burn out' but also guards against doctors becoming damaged by difficult clinical interactions and in turn damaging the patients they see".

The emphasis is once again on the clinician -patient relationship. Often members diverge from this primary task of the group, perhaps as a defense mechanism to avoid negative emotions being brought up by the presented case. The group leader/s must then steer the group back to deal with the relationship thereby minimizing offers of advice, blaming the system and so on. Many of us use the push back method in which the presenter does not take any part in the verbal metabolic process but takes up a position of active listening allowing him/her to concentrate on the work.

The group becomes a container for the thoughts, feelings and behavior of the presenter in a safe, empathetic and non judgmental environment.

Composition: Embracine belongs to a pharmacological group entitled

EMPATHOMIMETIC KREXIN INHIBITORS.

Doctors who regularly participate in a Balint group show more patience and understanding towards difficult or complex patients or those that present with multiple unexplained symptoms. Our colleague Dr Amir Mendel presented a paper at a Baling meeting in Slovenia several years back in which he showed that 80 % of the family physicians who attended a Balint group that he led reported an improvement in their feelings towards their patients and work as a result of their work in the group.

In an article published in 2014 in the Journal of Psychosomatic Research, Guillaime Airagnes and colleagues showed that Parisian medical students who attended a Balint group improved their empathetic ability. Using the INTERPERSONAL REACTIVITY INDEX these students had higher scores than students who did not participate.

Hence we have shown that Embracine is Empathomimetic.

Group members may gradually reach a deeper level of understanding of their patients' and their own feelings. They may realise that certain patients provoke emotions that may resonate with what is going on in the own inner lives.

We all have our list of "heartsink patients", patients that cause us to instinctively react with inner thoughts of "Not again", "Why me", or simply "Oh no!!". In the Yiddish language these sighs of anguish are called "Krexin" and regular doses of Embracine have been shown to reduce the intensity and frequency of these thoughts/krexin. Hence it is a Krexin Inhibitor.

Therapists/doctors who are aware of these negative feelings and are willing to examine and search for ways to modify them will suffer less. The secret is to learn via the work in a Balint group to identify the counter transference as it happens in the clinical setting and react accordingly.

As Dorte Kjeldmand concluded in her often quoted paper published in the Annals of Internal Medicine

"The GPs in this study described their Balint group participation as beneficial and essential to their work life as physicians in several ways. It seemed to increase their competence in patient encounters and enabled them to endure in their job and find joy and challenge in their relationships with patients. Balint groups might thus help GPs handle a demanding work life and prevent burnout."

Dosage and strength: There is no real consensus on this issue. Some groups may have 4-6 members while others as many as 18. Some people take an occasional SOS dose like by attending a local Balint conference once a year in which case the drug usually has a short term benefit at best. The most common recommendation is to take a maintenance dose of between once a week to once a month. As with other medications, the efficacy increases at the higher

dose but compliance and adherence have been shown to drop.

Embracine can be taken before, after and occasionally with meals. In some groups these social interactions become an integral part of the group format leading to an increase in intimacy between group members. Even though the work itself is done primarily per os, one often comes away from a Balint meeting with an injection of empathy and compassion.

Pregnancy and breastfeeding: Embracine is a Class B drug with no evidence of negative effects on the fetus. The subject of breastfeeding is more complicated. Whereas there is no danger to the mother or baby, the presence of a baby in the group can decrease absorption of the material amongst some group members. On the other hand, it may make the group more intimate and increase member bonding

Mechanism of Action or simply "How does it work?" In some instances the case presented is solved just like an ordinary medical case. The presenter presents the case, the group with the leaders' guidance reflects on the case and the emotions evoked and at the end the presenter comes away with a useful insight that enables him/her to re-engage with his-her patient in a more empathetic manner.

But this is not always the case and possibly one of our greatest challenges is to explain that this is not what we are trying to achieve in our work. I prefer to see the case as a gift given to the group by the presenter and on which all members, even those who do not say a word throughout the session, can do their own processing thereby going home with possible new reflections relevant to their own clinical work.

Ongoing participation in a regular group or taking Embracine regularly allows amongst others:

Sharing experience with colleagues interested in relationship issues.

Restoration of empathetic capability towards challenging patients.

Understanding feelings in both the doctor and patient such as anger, identification, and affection and how these feelings effect the relationship.

Improvement of interpersonal communication.

And finally Side effects and allergies.

Balint Groups are not therapeutic in nature so the risks to individual participants are minimal, especially if the leaders are competent in providing safety. Some members may initially experience mild symptoms of dry mouth, palpitations or abdominal discomfort but these usually dissipate over time.

There are, however, a large number of therapists who develop allergic reactions. These can be divided into two groups. The first is an immediate contact reaction. Having received an invitation to attend a Balint group for the first time we may hear statements like "who needs it" "I'm too busy" or "I have no issues".

In order to explain the second type of allergy let's go back Michael Balint's book title. In Balint groups we touch on all three components.

"The illness"- Our patients come to us with a myriad of complaints with the expectation that we can solve most of their problems.

"His patient" or from the patient's perspective "My doctor". Some of us have held this title having treated a few thousand people for a career life time often spanning close to forty years. In our Balint groups we often bring some of the more complex relationships in order to get a clearer understanding of the burden of responsibility that comes with that title "My doctor/my therapist/ my priest".

In Balint work we need to acknowledge our role in the imperfect therapist/clinician-patient relationship. Those who cannot acknowledge that they are imperfect, make mistakes and cultivate unhealthy negative feelings towards certain of their patients, cannot in my view benefit from or enjoy being part of a generic Balint Group. They develop an allergic reaction which presents as frustration, aggression or contempt towards other group members.

Balint groups are therefore not a pill that we should all swallow. It is important that we do try and find other ways of combating burnout.

Yet Balint groups open to us a crack in our biologically trained wall, an emotional insight, contemplation, a deep reflection within and about ourselves. Therefore it is fitting for me to end my presentation with the words of my favorite singer, Leonard Cohen and his song Anthem, the chorus of which symbolizes for me the essence of Balint work

There is a crack in everything

That's how the light gets in

Thanks for allowing me to shed some light on how Balint groups may be seen through the eyes of a pharmacologist.

In Between Spaces - Strangeness and Togetherness in Balint Groups

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Abstract

The presentation "On Balint Trails" presented at the Oxford Balint International Congress in 2017, on Michael Balint's journey to Budapest, his home town and back to England, drew attention to his feelings of strangeness. The late Benyamin Maoz, a father of the Balint movement in Israel and known to many of you once said "Balint groups is a home for doctors who are homeless." Following these themes the authors describe the emotional process between spaces and between strangeness and togetherness in Balint groups. The journey will be described through the experiences on the way to the Balint conference, in the group process itself and on the way back home. Our paper will be highlighted by insights from three groups along with relevant citations from Julia Kristeva's book "Strangers to ourselves" and Fernando Pessoa's book "The book of disquiet" – "Livro do Desassossego".

Introduction

At the Balint International Conference in Oxford, Esti Riemer¹ and Raluca Soreanu² mentioned

what Michael Balint wrote in 1961 after his visit to Budapest, his birthplace:

"I could speak Hungarian, but still didn't feel at home. I knew every street, almost every house and still was a foreigner. When finally we got to the English plane where a nice simple English steward welcomed us, I felt home at last. Still, the sense of homeliness is felt while on the plane, in between spaces".

The late Benyamin Maoz, a father of the Balint movement in Israel and known to many of you once said "Balint groups is a home for doctors who are homeless." Benyamin passed away over five years ago while Michael Balint passed away almost 50 years ago, yet the legend continues and tickles our imagination.

In our manuscript, we shall try to understand the overt and covert meaning of "A doctor without a home?"-how do we understand the concept of "between spaces" and what is the secret of our Balint activity where we search for an answer for our feelings? Do the feelings of being nomads in our search for a comfortable professional home have an effect on us as group leaders? Does it resonate in the group itself? Does our tendency to often feel addicted to our Balint activity generate from the same search?

Our discussion will look at the issue from philosophical and emotional perspectives with reference also to the literature.

In our paper, we would like you to wander with us as strangers, through the feelings of alienation and togetherness in our Balint activity. In our wanderings we shall try and gain some insight through the writings of Julia Kristeva and Fernando Pessoa.

A little about Kristeva

She was a psychoanalyst, linguist and French author from Bulgarian background. She examines the philosophical, psychological and sociological aspects of strangeness. It appears that she knew the subject well since she lived the most important part of her life in France and wrote in French too. In her book "Strangers to Ourselves"³ she describes the feelings of strangeness:

"Not belonging to any place, any time, any love. A lost origin, the impossibility to take root, a rummaging memory, the present in abeyance. The space of the foreigner is a moving train, a plane in a flight, the very transition that precludes stopping."(p.7).

Now we shall wander with Fernando Pessoa, a writer who lived most of his life in Portugal in his book "The book of disquiet" - Livro do Desassossego⁴.

A little about Pessoa

Pessoa was born in Lisbon, was orphaned from his father at a very early age and lived most of his adolescent years in Durban, South Africa, when his mother remarried the General Consul of Portugal in Durban.

In 1905, after completing his formal schooling in South Africa he and his family returned to Lisbon where he lived for 30 years until his death in 1935. After his death 27000 pages of texts, poems, critical reviews, philosophical texts and plays were discovered hidden in a wooden box, some of them related to his book mentioned above.

Our private journeys in this presentation will include three parts: Our journey to the Balint conference, our journey at the Balint conference itself and the groups, and the journey on our way back home after the Balint conference.

Journey to the Balint conference

The excitement begins even before the conference. How good it is to leave the clinic, the busy ward, the usual consultations and patient care and to travel to our Balint conference. I imagine the journey...the excitement at the meeting and chatting with my old Balint colleagues and the new ones before the meeting, and the relaxed atmosphere at the meeting. There is something very calming to know that at these meetings there is a feeling of non-judgment and non-criticism. Then there is also curiosity: Who will present? Will it be my colleague from far away whom I remember from the previous conference? Maybe even a work colleague of mine?

Fernando Pessoa writes:

"There is a small number of restaurants in Lisbon like an inn, where above the ground there is a top-floor hotel that looks like a decent inn that rises to the level of a restaurant in a town where there are no trains, and on the same intermediate floors there are times when you encounter strange types. I began to look at him more attentively ... One day there was a fight between two people on the street, those on the intermediate floors ran to the windows and I was among them. So was the person I was talking about from that day on, we began to greet one another for peace ... a day on which the absurd coincidence brought us together to find a safe place for his thought" (1915).

From these writings I see parallels to Balint groups- The safe inn is analogous to the system. The middle floor can be seen as the group. The brawl can be seen as case presented in the group, the widows can be seen as the way the members of the group see the case presented, while the mirror may reflect the group members themselves. In our Balint groups we seek out the middle floor, a safe place where we can feel at home while mixing at first with strangers.

The opening meeting at the conference

At the opening session of our conference we have an open session before we are allocated to groups, where we ask the participants in a circle with what feelings they came to the conference? At this meeting the participants emphasized their desire to find a common language relating to professional dilemmas, to reveal these conflicts and to echo complex feelings. I feel that I left my workplace, difficult patients, an irritating boss, a demanding and stressful medical system and have arrived at a calming place, like coming home to family? Then sneaky feelings of discomfort or maybe anxiety overcome me.

The group has its own rules run by experienced leaders; yet, will the feelings of freedom and "coming-home" continue?

The journey to the group

After many years: A journey back to my Professional Homeland in Balint group:

I'm a psychiatrist and I was glad to see a colleague from previous conferences, a social worker who once worked with me in a department where I once worked. This eased my tension. In the group the presenter brought a dilemma involving the difficulty in rehabilitating a patient with a personality disorder and complex marital issues. The patient is suspicious of the rehabilitation system, which in the past, did not fully address his needs and thus sabotaged the rehabilitation process. Despite this, the social worker is determined to continue the process and to include family therapy in order to encourage rehabilitation. In the department, the other doctors diagnosed schizophrenia with low chances of rehabilitation, but the presenter finds himself justifying the patient's claim that require a more comprehensive rehabilitation approach towards his problems. The presenter reports his great deal of emotional involvement and the intensive time invested in the patient, while the system demands, on the other hand, that a limit should be placed on giving family therapy. The presenter fights for the reasonableness of his therapeutic approach, despite the difficulties. He shares with the group his own family background, which led him to choose the profession and which gives him the courage to fight the system in his way. In the group, there are voices expressing the rigidity of the system and the tremendous sacrifice that the presenter undertakes to sustain his professional beliefs.

And where does the case touch me?

Feelings of the past rise up in me, the need to be the representative of the patient who fights for his rights in the system.

I remember, as a psychiatrist, my previous emotional investment and difficulties in trying to treat patients with the "hat" of a family therapist. Due to these difficulties I myself reduced the use of long family therapy meetings over the years. The discussion of the group is accompanied

with frustration and the feeling that the system is not open to long-term systemic interventions due to economic- systemic constraints.

I share my feelings with the group: the difficulty of combining family therapy in an over-loaded psychiatric daily routine in the general hospital is still a continuous challenge. I also share my jealousy of the social worker's courageous approach to stand for his beliefs and share with the group his past story.

The Balint group allowed me also to hear a colleague of another department discussing his difficulties too. This was a sort of opening an inner window of my past challenges which decreased the feelings of my alienation in the group.

And then I had the insight that in order to be understood, I must share my emotions and conflicts. I asked myself questions: Where did I begin my career? What were the difficulties at the beginning? What were the emotions that were present at the different stages of my professional development?

Kristeva writes:

"And what about your origins? Tell us about them, it must be fascinating!.. The foreigner, precisely, like a philosopher at work, does not give the same weight to "origins" as common sense does. He has fled from that origin - family, blood, soil-and even though it keeps pestering, enriching, hindering, exciting him or giving him pain, and often all of it at once, the foreigner is its courageous and melancholy betrayer, his origin haunts him" (29-30).

The journey in the group

"Doctor and father" - the stranger who evokes "the known" or "strangers meet strangers":

The group now described is a Balint group for fourth year medical students as they enter the Internal Medicine department. A student presented a dilemma. "We just entered the ward, we do not know anything, it's not always clear to us where we should be, by the patient's bed or with their families?". The student presents a 55- year-old man and his family in the ward. The patient, a new immigrant, who does not understand Hebrew, was hospitalized with chest pain. The student tried to talk to him, to do a physical examination, and until the patient managed to express what was hurting him, in his unfamiliar language, the student had to leave the ward at the end of the workday. He passed the case on to the house doctor. The student wanted to share with the group a feeling of missed opportunity that he had been feeling for several weeks.

In the group, students shared thoughts and feelings of frustration about immigration, understanding different foreign languages they encounter in the department. Yet, something was not fully understood at the meeting, not by the students nor by the facilitators. Then the

student admitted: "My frustration was not only about my misunderstanding of the patient, but because I had to run to take my daughter from the kindergarten at a quarter to four. I was torn between my professional obligations to continue to talk to the patient and complete the medical history and the sense of urgency I felt that I had to get out of the situation quickly, to bring my daughter from the kindergarten which closes at 16:15."

The surprise was great, causing a liberating feeling of laughter in the group. The facilitators looked at each other with amazement: This is the magic of the Balint groups! There was a sense that the banality of life was stronger than anything else which was shameful to confess to others. The student added sorrowfully: "For the first time, I understood the limitations of my ability - my professional work and my private world, the emotional price I have to pay, and I understood in this group that I was in my father role rather than in the doctor's one." The facilitators noted that it was an illustration of a meeting between two strangers: the foreign patient and the doctor who felt alienated in the ward and even a stranger to himself, in a place where he was supposed to feel at home.

Balint groups create a professional feeling of homecoming - the ability to share the "discomfort" of the small banalities of our professional lives.

Pessoa says:

"As I walked down the slope of Nova Du Almada today, I suddenly noticed the back of the man walking in front of me: it was the mass back of a human being, the jacket of a modest suit on the back of an accidental passerby ... I suddenly felt a softness toward this man, the softness they feel toward ordinary human masses, the daily banality of the head of the family who goes to work, the innocence of life without surgery".

On my way home from the conference

Feeling of closeness and intimacy erupt in me. Then unexpected feelings overcame me. At the conference there were old and experienced Balint veterans among the young participants, a welcome change. I ask myself what about myself in the Balint life cycle? And so, our last leaders' supervision group came to my mind:

From a leaders' training group: "Who will look after the Ballintians house?"

We are a group of facilitators who meet for a leaders training group every two months. Our meeting place, in the home of one of our colleagues, has already become a familiar and safe home for an open emotional discussion of leaders' dilemmas. Our group leaders, having led the leaders training group on a two years rotational basis, are about to be replaced by two others. In addition, our host, is about to move to a new home, and this is the last time we meet here in his home. There is an atmosphere of separation in the air.

The meeting begins with a longer than usual silence. At the end Assaf shares his story:

"For several years me, a social worker with a psychologist, have been leading a group of veteran family doctors. I feel that the group, after many years, is declining and the group "is about to die". Suddenly, we were joined by four other participants, they heard about the meetings and decided to come.

"My dilemma", the presenter continues, "is that as a leader, I feel working hard to maintain the rules of the Balint group, I feel obligated to maintain our professional home: emotional sharing without complaints about the system, while the second leader, the psychologist, allows the group members to talk freely about their frustration of working within the system."

The participants highlighted a few issues that emerged from the story of the presenter. The first is related to the differences of opinion regarding the style of leadership. Participants noted that the professional similarity between the two mental health professionals, who came from the same "professional home," sharpened the differences in leadership style, perhaps also created a sense of competition and loneliness felt by the presenter. Is it possible that because both come from mental health professions, this may have refined the "narcissism of the small difference"? The presenter wondered: "Do we have to talk more about the differences between us?" Other members spoke about the feeling that maybe the presenter had exhausted his position in the group and wanted to terminate his relationship with his co-leader. It was a good discussion and I thought that maybe the four new members might have revived the group: Can we as "parents" guide our "children" and make the group a "home again"?

The newcomers may have brought a sense of freshness into the group, yet what kind of feeling does this invigoration caused in the presenter? He may feel that the house is changing yet he walks around like a stranger? These estranged feelings may have become even more pronounced because of the differences in leadership styles.

Feelings of farewell, of separation were also felt, perhaps connected to the leaving of the physical home where we met, or related to the separation from the group leaders.

Epilogue

On my way home, I have mixed feelings of great joy and uneasiness. Then the words of Pessoa resonate again within me:

"The journey is in my head: In the plausible intimacy of approaching evening, as I stand waiting for the stars to begin at the window of this fourth -floor room that looks out on the infinite, my dreams move to the rhythm required by long journeys to countries as yet unknown, or to countries that are simply hypothetical or impossible"

***The author wants to thank his wife Ruti for her useful contribution.**

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Cap. 08
Ascona Prizes

Recreating Thoughts: The Person, The Illness or The Tattoo?

João Paulo Mertens Brainer

"I do not think you will be able to help me, to be honest, no one can."

These were the first words I have ever heard from a patient during my first year at medical school.

No, it did not diminish my will to help her. In fact, it only made me eager to do so. But the problem was: I had no clue where to begin.

"Respect", "Care", "Suffering", "Building Rapport" might be some of the most used terms in a patient-based lecture. Yet, in a way, they seem to fail in demonstrating how deep and meaningful this interaction can be.

"It is obvious," I thought during most classes. For me it was not a surprise, just common sense repeated over again in different ways.

I was anesthetized by my own inexperience, blindfolded by my arrogance. I had never faced a situation where I had to use this knowledge in a practical manner, and the truth is I was just beginning to have a grasp of its full meaning during my first day at the public health care center.

I live in Brazil, to be precise on the northeast coast, a city called Recife where breathtaking beaches and yearlong summers contrast with extreme poverty and violence. More than a half of the population - over 1 million people - earn their living with less than 3,5 US\$ per day, struggling for access to clean water, basic education and work. Despite our no cost public health care system, the lack of equipment, poor structure and corruption contribute to suffering, skepticism and vulnerability.

Still, standing out in the middle of the crowd, one person taught me the value of empathy.

I divided this report into weekly encounters that I experienced during my visits, according to my field diary. I also managed to save some dialogues, which will appear as events unfold. It was not easy to write this narrative, since emotions were evoked, as I wrote each part of the text. It is meant to be a reminder to empty ourselves of prejudice and enrich us with affection for this compelling calling: Medicine.

We were assigned to visit one of the public Primary Care Units and ask the local citizens to answer a questionnaire regarding quality of life, which included questions about their age, number of children, what they use the public health care for and a few others. I was allocated in one unit called Planet of the Apes.

I admit I was concerned.

The idea of a place like that hammered in my mind for many reasons.

The name itself was already difficult to digest. Even worse was the comment of previous students, highlighting it as a resourceless community where violence revolved around them. In possession of that information, I just could not understand how this experience would benefit me in my future career.

Finally, the day arrived.

I remember it clearly, it was a Tuesday morning and, to my misfortune, I was right: My Judgmental expectations were filled. On top of this, I found out that half of the locals lived in the midst of dirtiness since the garbage collector would only come by once or twice a month, at the most. Still, most of them had already lived to accept that. "That's the way it is," some would say. That being said, I was not sure how a first year student like me could help those people or how they could help me in pursue of being a good physician.

Perhaps it was too soon to conclude that.

I looked around and decided to start with an enthusiastic grey hair lady, who appeared to be in her mid 70s, seating in a plastic chair in the waiting room of the Family Care Center.

I introduced myself to her, as she consented to do the interview. Somewhat excited, she promptly answered all the questions asked. But before I moved on to the next person, I had this last question for her.

Not expecting much, I asked:
"What do you like to do for leisure?"

As simple as it seems, I was surprised:

"This is what I like to do," she said emphatically.

At first, it made no sense. She was not doing anything in particular apart from sitting in a chair inside the facility.

"What do you mean by that?" I inquired.

"This."

She paused for a second and continued: "When the students like you from the university come down here, and ask me how am I doing, and what I like to do, it really makes me happy, I wish you could come more often."

Not prepared for that answer, I smiled back at her.

How come a simple act like that could make someone happy?

And the conversation continued:

"You Know," she said "I have come here once a month for the last 10 years of my life. The doctors... they never listen to me, they like to prescribe me a lot of pills, though."

I carried out over 20 interviews that day and most of the interviewees would say something similar "You just made my day," or "Thanks for coming, I was wondering when you students would show up again."

It is impressive how simple actions and attitudes, such as a smile or small talk sometimes motivates and comforts people more than we can understand. It does not require a herculean effort or long-lasting sessions to change a person's perspective. They all want to feel listened to, and to know that somebody cares. Had I not had this experience, probably I would not have realized the importance of such a simple attitude.

She also mentioned that usually the doctors would not listen to her or - at least - she did not feel listened to.

The fact is: They probably focused on her disease instead. Often times it gets confusing, but they are not the same. A patient is not their disease. They are not just something in between illness and antidote. This idea can definitely jeopardize the Patient Doctor Relationship.

This way, I started to change my perspective on things, but my biggest surprise was yet to come.

Encounter #1 Meeting Miss Molly

In the following week, I returned there, this time, the assignment was to propose a Unique Therapeutic Project (UTP), as a set of therapeutic measures and strategies articulated altogether with the Health Care professional team aimed to solve the multiple demands of a single patient. In other words, we had to choose a specific patient and, with proper assistance,

propose possible solutions to help them treat it.

Miss Molly was the one designated for me.

Doctors would often refer to her as the "tattoo case" since she had her body literally covered in tattoos. Situations like that happen quite frequently when a patient has a particular characteristic or disease. It is probably easier to remember that than their actual names. Still, she was a lady with a heartbreaking life story.

Dr. Marta told me that Miss Molly had been diagnosed with depression a long time ago, recently suffers from occasional anxiety attacks, during which she gets herself a new tattoo. Adding to that, regarding her personal history, she had just lost her job and there was an unknown cause of edema in her legs. She would barely go outside her house, even if it was to check on her own health in the Family care center two minutes away from where she lived.

"What are we supposed to do?" I begged an explanation from the Family Doctor, clueless even on where to begin.

"Support her" she said.

There was not enough time to prepare, her house was just around the corner.

And there we went, knocked on the door, and waited to face what, for me, was a challenge.

Miss Molly came to our encounter, a lady, in fact, with all her body covered in tattoos, just as described. The doctor introduced me and asked if I could talk about her life and condition in the following three weeks, at the end of which we would meet again with the clinician to formulate a Therapeutic Project.

"I do not think you will be able to help me, to be honest, no one can. Even so, he is allowed to talk to me, I guess."

This is how I was greeted by Miss Molly at her doorstep, reluctantly looking to the family doctor.

We shook hands as I entered her house. There hardly was light, apart from the sun that shined through the only window I could perceive. At this point, it was only me, Miss Molly and her daughter. We sat down, no one talked. I guess no one had a big expectation about that encounter, neither me nor Miss Molly.

I decided to take the initiative, starting by asking about her, what her interests were and similar questions.

"I used to run, but it has already been a long time since I quit," she said, while avoiding any

kind of eye contact.

"Why is that?" I questioned.

"I just do not have the will anymore, I prefer to stay at home."
We kept talking for a while, and all I got was general and effusive answers like that. Which rapidly changed when I addressed the "Family" topic:

"Do you have any siblings miss Molly?"

To my surprise, she bolted towards her room, and locked the door.

I was shocked.

A thousand thoughts went through my mind. I had no idea I was not meant to address this topic. At that point, I was not authorized to see her entire medical records nor was I advised to do so.

"Don't worry, she always does that; last time she burned her entire photograph album with a cigarette lighter and, right after that, she regretted it. Even tried to assemble the torn pieces left," whispered her daughter.

That explanation did not make me feel better at all.

Different emotions and questions dwelled in my mind. But the loudest one was: How am I going to help her? I'm not a Doctor, and, even if I were,

She would not take her pills,

Would not go outside,

Would not seek help.

What could I possibly do that no one has tried yet?

A few minutes passed and, as she opened her room door, she stared me right in the eye, changing her countenance. Clearly perplexed, she said:

"How come you are still here? I thought you would be gone by now; I am sorry for what I have done."

"As long as you are not uncomfortable, I am not leaving, I guess we just have to find a more suitable theme for us to talk about, right?"

She nodded, giving away a smile, the first one since I got there.

From then on, surprisingly as it might seem, the conversation went much smoother than before.

I remembered what that enthusiastic lady told me a few days back, the importance of listening, not with the intent to propose treatment nor to diagnose, but to have empathy towards the hu-man being that exists on the other side of the disease.

Right after she finished her last story, after all those tempestuous feelings compiled in a two and a half hour visit settled down, she said:

"You were the very first one that could put up with me, listen until I had finished, nobody could ever endure more than the first 15 minutes and, back then, I did not feel listened to at all. I don't know whether you can help me or not, but I hope things can be different." As she shed a tear, her daughter went on to comfort her.

The truth is, when I noticed she believed that I could somehow help her, I was the one comforted by that sensation. "She trusts me." I thought aloud in my head.

Despite all of that, this frugal happy sensation quickly faded away as I realized the serious re-sponsibility that I now had towards Miss Molly - I just could not disappoint her.

I was scheduled to come back one week later but my mind just could not keep me away from that, my thoughts would go astray about what should be done when I met her again.

More and more things fitted together, rather than anatomy or physiology I suppose I was meant to be human. Knowing that, however, was not the tough part. Notably challenging was how to make her comfortable to express her heart, without fear of being deemed weak. I felt I was on the right track to accomplish that.

One week had gone by on a snap of fingers, and now, I find myself waiting in front of her door-step one more time.

Encounter #2 The Empathy is Real

"Miss Molly can I come in?" I shouted.

And to my surprise, she came to greet me slightly, but noticeably, differently than before.

For me it was no longer an assignment. I was dealing with a person's life. I did not have any se-cond thoughts. I had to move forward, though, I did not know exactly how to accomplish that

yet.

"You look great today." I told her as an attempt to boost her self-esteem.

"Thanks for stopping by." she replied with a gentle smile on her face.

The conversation went on and she started telling me, sooner than I imagined, some sensible sto-ries of her life. She began to describe all the times when she was molested over and over by her father, all of which, with her mother's consent. "It began when I was 9," she said. At the age of 12 she was thrown out of home because she would not put up with this anymore. At that time, a male friend of hers offered a place to stay in a house two blocks away. "He was almost 10 years older than me and that proved to be a big mistake," she admitted. Years later, that man became her husband. The joy ended when he started beating her up and abusing her, due to alcohol ad-diction. Later on, at the age of 22 she started to have what she described as "Rage attacks", in which she would destroy everything near her, and, right afterwards, go get herself a new tattoo.

A couple of years later she divorced her husband and with the help of her aunt decided to look for a job. That is when she became a bus fare collector. "I cannot say I was ever happy, but at that time I felt useful." It did not last long as in the five years that followed, she saw herself stalked and abused by her ex-husband.

Her only daughter, Melissa, was born from that abusive relationship. "I started taking meds, anti-depression pills, by myself. I knew the owner of the local drugstore and he would give then to me out of pity. After a while, I stopped taking them because the Family Doctor found out and forbade it. But now, I don't really care anymore, I take the new pills she prescribed to me every other day, and that is how I've been living for the past years."

After she finished, a long awkward silence invaded the room.

I just could not find the right words. I was paralyzed both by apprehension and by my incapabil-ity of doing anything.

Her daughter who was watching it all but had not spoken until then, was clearly touched and said:

"She used to go for early evening walks every day when she returned from work, she loved it, but now, it's been months since the last time she went out. The neighbors, they come by twice a week to check on her, but she never talks, and mom has gained a lot of weight lately," she added.

I spoke what felt right in the moment.

"Miss Molly, I am glad that you trusted me with your story, you are a very strong person, and your daughter really seems to take care of you".

"She does. Melissa is great!"

She paused and fetched some water for us.

In the meantime, I could only wish I had the power to take her suffering away. Her aged face, delayed mobility, life story, I was trying to digest all that information, almost like a nightmare.

Minutes later she returned with a water jar and handed me a glass with a trembling hand that looked much older than it really was.

"I appreciate that, Miss Molly. I was thinking about your story, I must say that, I cannot imagine your suffering, I am truly learning a lot from you"

At that moment she held my hand in appreciation. As I held hers back, Melissa joined us, and whispered with a soft voice, "Thank you, thank you for helping my mom."

On my way home I thought about the reason why she was thanking me.

I had not done anything until then. It was only my second visit but I felt that I had known all Miss Molly sufferings long before.

In such a short time, I could unveil so many emotions and learn so much from her. My definition of empathy was no longer the same. All the scars that she carried, and despite that, deep down inside she was waiting for someone to care. To help her realize that there was still time to fight, and perhaps my mission as a medical student was to point that out to her. Not to prescribe pills, not to propose treatments, but to listen to her fears and her feelings as someone who truly empathized with the pain she was going through.

Later on, my physician mentor informed me that there is a subtle difference in trying to help as a professional and being emotionally invested in a patient, which can blur our conducts. I guess how to measure it carefully is the key point.

Encounter #3 Improvements and struggles, the power of words

The purpose of the third visit was to understand the reasons why she was so reluctant to search for help. At this point I knew her entire life story, everything was happening so fast.

I remember arriving early that day and sensed a better atmosphere in the environment. Her household and furniture were shinier than ever before. Her brick house seemed as charming as it could be. I was welcomed in with warmth, "I was waiting for you, come in," as she led me to my usual chair, right next to a simple, but cozy, bench. Her daughter promptly joined us bringing a

glass of water. "I'm really sorry I cannot offer you anything to eat," she said changing her tone. "As you know I'm unemployed, and the government aid happens to be delayed."

"Not a problem at all, I come here because of the company not because of the food." I said, managing to cheer her up a bit.

Right after that, we began talking about her past medical history, she disclosed her feelings and hopes towards the future and the following hours went by peacefully.

It came to my attention that her biggest fear was to receive a reprimand from the doctors, which is why she refused to go to appointments. A sort of "White coat Phobia", afraid of disappointing both the doctors and herself. I told her that I saw other patients sharing that same concern but, actually, the doctor was there to help, not to arouse fear in her. Sometimes I thought I was overstepping my role as a medical student, but I had little guidance until then and decided to share it later on with my mentor.

"I guess I'll see you next week." I told them as I stuffed my things in my bag and set myself up to go. When I was just about to leave, she turned to me with a somewhat thoughtful face, hesitated for a while and said,

"I'm thinking about going to the family practitioner next week, I guess I need to set my meds straight."

"It is a great idea Miss Molly." I promptly responded.

Finally, practicing patient-centered medicine made complete sense to me. Despite all the limitations I thought I had as a medical student, I learned that, in fact, these enabled me time to develop a stronger bond toward her. I might have exceeded my role there. As I said, I am aware of the importance of maintaining professional boundaries, but since it was my very first experience outside the walls of the university, I was confused on exactly what my approach should be. I found out the hard way, or should I say, the better way. I was allowed to deal with something greater than my expectations, shaped in my will to help.

The more I thought about this the more I noticed that it is not about being flawless or not committing any mistakes. Most people that I know had at least one bad experience with a doctor. But, even so, I guess that as a doctor, we must accept our successes and failures, and realize that we are in a constant need to improve and with every new patient comes the urge of learning more and more. It also must be said that every day we deal with different situations and how we face them is what determines truly humanized doctors. Socrates said over 2000 years ago that we must constantly question. We must question our attitudes and question our behavior in order to pursue happiness in life. Always reflect upon it. It is not easy. I have just begun my journey to become a doctor and I have already experienced so much, I learned some of the fears and dreams of someone in pain.

Hopefully, this feeling will help me perceive in a new manner the life of those on the other side of the table.

I didn't want this to end.

During these past few weeks, I was immersed in a world I did not know existed. I was flooded with my own misconceptions, certainly the psychological dimension was harder to interpret than I could ever predict. While I would complain about my problems, I found out they were meaningless when compared to hers. Nonetheless, I figured if I were in her shoes, I would probably feel the same way she did. Thus, I approached her the way I would have liked to be treated if I were the one in pain. Only through example can we make a difference. To quote a conspicuous scientist: "An example is not the best way to influence others. It is the only one."

It is also worth mentioning that during med school we are encouraged to repeat the Hippocratic oath, the very first commitment of western medicine.

They are not just words. Their symbolisms echo throughout generations and keep inspiring and - at the same time - guiding physicians in their approaches toward the patient. Sometimes it is hard to acknowledge that. People like Miss Molly help us recall our commitment to the person, not to the disease.

I also learned that the white coat has the ability to either inspire fear or help patients overcome their struggles. Some will not open up to doctors as they are afraid of being judged, so I felt it was my duty to encourage moments of sincerity and focus on the emotional background hidden by the infirmity.

Another valuable lesson I would like to share, as simple as it might seem: Be humble. Everyone always has something to offer, no matter where they come from, their gender, ethnicity or income.

We can always learn.

But in order for that to happen I had to admit to myself that I was wrong. Miss Molly never went to college. In fact, she dropped out of school in the fifth grade, yet, no book could teach me what I learned from her - the real meaning of what it is to be a health care professional.

Encounter #4

How to convey a message: the power of knowledge

Here I was. This was my final encounter with Miss Molly at her house. Apart from that, we would only meet again in the basic health care unit two weeks from then.

My job this time was to ask Miss Molly if she understood the conditions she had.

"Come in," she said as I made my way to sit in the same chair I did every week.

"I want to show you my new prescription, it turns out I was not taking my meds right."

"But now you are," I replied.

"I know." After a pause she continued, "But I have wasted so much time in my life. The doctor insisted that I take these pills every day and schedule appointments more often. I don't know if I am able to do that, that is who I am"

I looked at her and said: "Even so, you look very different from the first day I met you. In fact

I guess we both are."

She smiled.

Still, I could tell by her attitude something was odd

"What is bothering you Miss Molly?" I said, giving her a chance to respond

She told me, in an emotional tone, about her neurologic condition and how she knew nothing about it,

I immediately offered some tissues I had inside my backpack.

"Miss Molly you are fighting it, you strike me as a strong woman, I already told you that, there is still time to understand more about your illness."

She took her journal, ready to write down her questions to inquire the physician, during her next appointment.

"My doctor, Marta, told me you can help me with that."

I gladly nodded "It would be my pleasure"

She felt relieved. Her countenance seemed to understand that it was not too late, there was still time.

During my presence there she wrote over 12 questions and the feeling of satisfaction spread across her face. "I am better than my disease."

I learned a lot that day. The acknowledgment of a disease is the first step to treating it

properly. And with Miss Molly it was no different, when she comprehended what her illness was about, she clearly felt open to treat it, and accepted it. "Cognoscere." It is a Latin term, which gave origin to the word we know as Knowledge. Aristotle among other renowned philosophers would use it as a way to pursue the one thing is missing in us. In other words, we can live to accept better what is happening when we learn it.

For this to happen, although, the use of medical jargon should be avoided. Patients occasionally place the physician on a pedestal, afraid to say when the meaning of a term is not understood by them. It is our job to be sure the message is put across well.

#Last Encounter Time to say goodbye: understanding vulnerability

It was a Tuesday morning. As I walked to meet Miss Molly, a strange feeling approached me. It was time to say goodbye. I remember the first day, it was so hard to start and now I struggled to leave that patient behind. The truth is I was afraid that our differences would make it difficult for both of us. In fact, that difference is what made me grow. We had developed a strong professional bond in a way I would never have expected. I did not have any medical expertise and in spite of that or, perhaps, because of that my objective was different: To laugh, to cry, and to deeply understand personal details of her life story. This experience turned my skepticism into compassion and my indifference into appreciation.

As for Miss Molly, in her attitude I could see that our interaction was also meaningful for her.

Perhaps she noticed I truly cared. I was able to see through her vulnerability, commiserate with the pain trapped inside of her and, in a way, my sense of powerlessness made me preoccupied about my conduct with her, careful to choose my words and above all just listen, spending time with her and build rapport. I consider myself privileged to have had the opportunity to change my concepts before I could actually prescribe. Though, in a philosophical way, I was already prescribing, not pills but affection. Still, I began to prepare myself for the future, empty of preconceived notions.

I arrived early in the Health Care Unit to meet the family physician. We discussed the details of her case, I explained what had occurred during my meetings with Miss Molly, she seemed to have approved what I had done, with some - not to say - quite a few considerations. Then, the time to see Miss Molly came. She was punctually waiting for us in one of the plastic chairs inside the facility.

"You look great today, Miss Molly."

"I know that." She said, while laughing. "It is very nice to see you."

We directed her to the entrance of the appointment room.

Sitting across each other, the doctor made her suggestions, and every treatment she proposed, Miss Molly made notes, as she looked both at me and at the doctor. All her doubts were patiently clarified during the appointment.

When the discussion was over, Miss Molly could not thank us enough. She appreciated all that was done and said that already felt better since the first time we met.

"It is time to part our ways," and, as she said goodbye, some tears were shed.

We remained silent. Not an uncomfortable kind, I guess we both reflected upon what that encounter had added to us. It was far from meaningless.

"Thank you, thank you, thank you." she said wishing me well on her way out.

"Miss Molly, I am not the one you should be thanking. The strength to face it was yours all along. Instead, I must say that I appreciate your allowing me to have had this experience. This last month has been of a tremendous significance to me."

She did not speak. I could tell the gratitude in her eyes as she nodded in consent.

Packing up her things, she thanked me once again and smiling, slowly left towards her house.

It was the last time I saw her.

I must admit, I felt incomplete. Actually I felt deeper than that, I felt as if I had somehow disappointed her. Although I knew I had provided assistance in my way, I did not cure her, nor did I have enough time to see if she was going to follow what was agreed on. I thought on it over and over again in my mind.

Later on, I decided to share this concern with a doctor whom I admired deeply.

He helped me realize that the definition of what I felt was empathy, respect for the one in pain.

That concept is often times confused with palliation for the conscience such as: "what a shame" or "what a pity". That is not accurate. In fact, it is the opposite of what should be done. Indifference is for the mind what poison is for the flesh, a dehumanizing factor that further increases pain and suffering.

Back in the university during the mandatory lectures, it appeared to be so much easier to understand than in fact it is.

Miss Molly, in her own way, enlightened me about why it is so hard to care for someone.

We see ourselves as in a mirror of our mortality. This dimension of our human existence is we do not always like to be reminded of. Thus, it is easier to push the empathy away, because when we start caring for others we also suffer.

At the same time, I learned that the joy of being able to do the best I can is a way to overcome that fear. Needless to say, we cannot save all of them, but we can certainly care for them, despite the differences.

When I reflected on this, I realized how immature I was.

At the beginning, I would, together with the doctors, wrongly refer to her as the "tattoo case". That label was very distant in describing what in fact she was: A life full of dreams, emotions and suffering - not an object, not a tattoo.

Another challenge I faced with Miss Molly was to interpret what was not only being said, but also the implicit words, the small gestures and hints that followed small snippets of verbal conversation. When I finally could understand that the pain goes beyond medical records and that spoken words are just a piece of the symptoms, I became a better student. In fact, not only that, I have the sense I became a better person.

Now, I wonder where the next step is. Certainly, many challenges along the way will follow, but as a wise man once said, life is about the journey not about the destination.

Miss Molly taught me how to manage my emotions, not to be overwhelmed, nor distant from the patient's reality. It's been one year since the last time we met. Still, I remember small details of that experience, I always keep that in mind, because life happens and, all of a sudden, we see ourselves in the same old routine, back into our comfort zone.

I guess the hardest part is to remember it in our daily life as physicians, and medical students, careful not to see a patient as another number and, this enchanting profession, as business.

I would like to finish this report by thanking Miss Molly for her time and great contribution to myself both as a student and as a person.

*Names have been changed to preserve their identity.

Mate

Leah Ginnivan

'Next there's an old guy with metastatic prostate cancer who's back from Sydney, he went home for a few days but came in with a bleed - we'll just palliate him I think' said the medical registrar. The consultant nodded, bored.

'Apparently he was snapping at the nurses in Emergency'.

'Any issues since?' asked the consultant.

'Nah, I don't think so'.

This was my first introduction to Rodney,* on a morning ward round in an outback Australian hospital. Upheaval at the impossible-to-staff hospital meant we'd been without an intern or resident for weeks, so as a third-year student I'd taken on the roles of note-taker, chart-finder, and ad hoc pathology assistant, and was left to roam the halls the rest of the time, trying to find a bored visiting specialist to teach me. My team was an ever-changing mix of mercenary locum physician consultants, and registrars on a despised mandatory rotation from a city hospital. The current medical registrar had taken an instant dislike to me, or perhaps just to the presence of a student, so I'd adopted a strategy of keeping quiet, deferential and out of her way. I'd been stationed at this remote outpost of the health care system for months, and by now I often knew the names, faces or families of patients, but Rodney was new to me.

I wheeled the computer into Rodney's bay, following the doctors. In front of us was an emaciated man in his late 60s. Like most men in this town, the stigmata of hard physical labour were immediately obvious - a missing finger, sun-gnarled skin, scars from wire and machinery gone awry.

I looked at his chart. Under the 'imaging' tab an x-ray showed an abdomen and spine clotted with metastases. Under the 'results' tab, last night there'd been a rapidly dropping haemoglobin - evidence of blood loss. Under the 'clinical history', there was a description of an emergency presentation for rectal bleeding and pain. Under the management plan was written '? social work referral'. I'd come to appreciate that social work referrals often just meant doctors felt unnerved by patients' expressed emotions - weeks earlier another registrar had referred someone for crying while complaining about the lemon jelly served as part of the clear fluid diet.

But on that day Rodney seemed placid enough in a crisp white hospital gown, staring at the local paper from deep-set, blue eyes.

'Well Rodney looks like things have settled down, we'll keep you here for a bit and see how we go okay?' said the consultant.

He stared up at us and nodded silently. He seemed bewildered.

'Good, we'll keep on going then.'

As we began to leave the room, he asked, 'Can I tell yas a poem?'

The registrar hesitated, but Rodney had already begun reciting his poem, which was on the theme of fallen soldiers, mateship and sacrifice. The doctors immediately stiffened, and exchanged looks which I took to be discomfort and contempt. As they averted their eyes, I felt irritated and embarrassed by them. So I looked at Rodney directly, and he looked back as he continued another verse.

'Well thanks for that, we better push on' said the consultant. The med reg pretended to take a phone call. The consultant nodded to me that we should leave. But it felt rude doing that, mid-poem, and one on these themes especially. Rural Australian men take their wars seriously. I hesitantly steered the unwieldy computer on wheels around the bed as the doctors left the room. As I drew the curtain back around his bed, I said 'Rodney, I'll come back and chat with you later'.

'Thanks mate.'

And so I did.

Over the previous few months I'd met so many men like Rodney. This particular town was full of his kind. They were men who, for diverse reasons – addictions, histories of abuse, money problems, mental problems, women problems – sought work in the isolated and masculine world of mining and station life, where they lived for decades. In their old age, they were extruded from the landscape by illness and disability. They staggered into the social world of town and hospital, surprised, having never planned for the eventuality of relying on other people.

At the hospital, I found myself drawn to these men. I recognised their confusion when a doctor was speeding through a jargon-filled explanation of what had happened to their body. These men were barely literate in medical language, with a host of preventable diseases the city doctors were never going to stick around long enough to really treat. I felt anxious and protective when I saw this – I felt like someone needed to show these men an alternative reality of dignity and respect, however futile their medical treatment was going to be in the course of things.

So after I'd finished my tasks, I'd visit patients on the wards and talk to them. Over months I'd refined my simple explanations for their pathologies – pancreatitis, haemochromatosis, diabetes, coronary artery disease, gout, and the strokes that they'd sometimes ignored for hours or days before calling the doctor. I drew pictures on post-it notes of what had happened – the liver 'rusting', the blood vessels narrowing, the gallstone lodged in the common bile duct

'You're not from the city, are you love', they'd often state, and they were correct. Though from a different part of the country, I was a farm girl of sorts, and I knew this phenotype. More than once I'd been handed a mobile phone and asked to tell a relative what was happening, or why a medication had been changed. I'd

be passed a specialists' letter and asked to interpret – 'it's jibberish to me, mate'. I felt proud, but conflicted, by how much this meant to them, and how grateful they were for this care.

And I understood how lonely these men often were, often simply craving someone to talk to who could mirror their emotions. It felt simple, straightforward, to compose a simulacrum of the person they needed, using my own constituent parts.

After rounds I read through Rodney's notes. It was a story of advanced prostate cancer, diagnosed late, on a background of depression, heart disease, a stroke years ago, and frequent presentations to the ED for pain due to metastases. He'd been sent to the city for palliative surgery and come back, lasted a few days at home before the most recent bleed.

Returning to Rodney's bedside, I sat next to him. 'Mate,' I said. 'It sounds like you've had a rough couple months'. His eyes brimmed with tears.

As I'd suspected, Rodney was utterly alone in the world.

He cried telling me about his estranged son, how his life had disintegrated after his wife died. He told me how, on seeing bright red blood in the toilet bowl, he thought maybe it would be his last day on earth. He cried while telling me about how he'd been in a car accident years ago, and airlifted to a major city hospital. In the weeks he was away, the council came by his house and collected his two Staffordshire terriers, thinking them abandoned, and 'put them to death'. He told me he'd tried to forgive those who'd killed his dogs but that he just couldn't, and he hoped he could before he died. He told me how for years, whenever he'd come into town from station work, he'd stop to get chicken nuggets from a takeaway joint near the hospital, and how much he craved them, that or a meat pie. And he finished reciting his poem to me.

A nurse came in to take some observations and smiled sweetly at me. 'Are you the daughter, darling?' she asked.

'Just the medical student.'

Later that week, Rodney's condition deteriorated, and he was transferred to a different team,

where he stabilised. I'd walk past his room a couple times a day on my errands, and I'd often duck in for a chat and to see how he was. Sometimes I'd get him a can of coke from the cafeteria when he asked and gave me \$2. Every time I visited, although I wore a nametag, he only ever called me 'mate', and I did the same for him – a mark of respect. Whenever I left, he thanked me for visiting him, and told me I'd be a good doctor.

After a few weeks, the social work referral came through, and revealed that Rodney's house was utterly uninhabitable and had probably been for decades, since his wife died. He'd been sleeping on a couch out the back, sorting out his pain meds on top of a wheely bin, and there were concerns about some nearby kids stealing his opioid supply. There was a "cognitive function" in his notes, but although I never tested his orientation to place, time and person he always was conversationally functional. It was decided he'd stay in hospital until a bed in a nursing home opened up. He kept on writing poems about soldiers making sacrifices for their mates and would sometimes read them to me. He was the right age to have been in the Vietnam War – but when I asked, he said he hadn't but respected those who had been and how terrible it was that they didn't get their dues paid to them. The injustice of the public towards the Vietnam veterans, who were only following politicians' wishes, was a topic of many conversations. Rodney identified with outsiders, and in different ways, so did I.

One day, we were chatting while the news was on. He told me he was starting to make arrangements for his funeral. He'd spoken to his son – they hadn't spoken in fifteen years – and hoped he'd make it up before then. I asked what his son had said, and he paused before admitting he had just left a voicemail.

'You never know mate, but it would be good if he could be there.'

He told me he was still thinking about the Staffordshire terriers and how sweet they were, and his eyes filled up again.

'You really loved those dogs', I said.

Turning to me, he asked if I'd come to the funeral too. I said of course.

One day I was visiting, and he told me it was his birthday next week. I was moving on to a different rotation in the hospital, but I said I'd stop by to say happy birthday.

A news story about the Sydney Mardi Gras was playing on the TV above his bed.

'Ah, mate' Rodney sighed, looking at me. 'I wish every fag in the world would be shot point-blank then hung from the Harbour Bridge as a lesson.'

I felt my chest tighten and my throat constrict, as I glanced up at the TV showing the parade. Bodies in leather, rainbow flags and glitter filled the screen. I knew my friends would be there – and that I would be there too, if I weren't here, in this outback hospital, having this discussion

by Rodney's bedside.

And for a moment, I didn't know what to do. Should instigate a discussion about human rights? Tell him, 'that's not appropriate' and politely wrap up the conversation, like the correct answer on a multiple-choice exam on professional ethics? Tell him about my own life, my own partner, in an attempt to foster tolerance and understanding?

I felt myself coldly detach, my feelings toward him turn from care to revulsion. He suddenly seemed shrunken and vitriolic, an angry old man.

I thought about all these men, my desire to be someone who could help them, and a cold rage that he'd dared speak those words aloud to me and think I'd agree. I understood his helplessness, his probably imminent death, and the futility of asking for anything from him. It felt futile to feel anything, but I still wanted to scream. Instead, I did nothing. He started flicking through the paper. I got up to leave.

'Thanks for coming by mate,' he said. He had absolutely no idea.

With as much cheer as I could summon, I told him 'no worries'.

Later, I thought about Rodney and couldn't sleep. Was he going to die alone – or would his son come through? Why did I feel so hurt by what he'd said – why did his views on gay people matter to me? I thought about how annoyed I felt when I saw doctors' referrals with their 'thank you for seeing Jenny, a delightful woman' 'thank you for seeing Ian, a man in his 50s with quite a difficult history' judgements. Why couldn't they, or I, just be professional? I realised that I wanted Rodney to like me – I wanted to be helpful to him. But why did his homophobia and therefore rejection feel so personal to me – even though he was dying, even though I barely knew him? I felt a deep sense of guilt – like I'd failed him by letting my emotions get in the way.

The next week, it was Rodney's birthday. I'd been busy on my new rotation and had not seen him since the comments about the Harbour Bridge. I had thought about it a lot, but it made me feel sad and panicked, and so I tried to shut it out. On my lunch break, I went to the takeaway shop – I'd become addicted to their immaculately salted chips – but I also had decided to bring Rodney some of his beloved chicken nuggets as a birthday present. I remember questioning whether it was a good idea, as I paid the \$3.50 for half- dozen chicken nuggets. I knew what I was doing was strange, but at the time I felt justified. I was no longer involved in his care, and I felt that this would be my act of forgiveness for someone I cared about, even though he'd never asked for my care, or my forgiveness.

I walked back to the hospital, clutching a paper bag of hot chicken nuggets, nodding to people I'd met in the town – some patients, some family members, some people from the pub. After only a few months I felt I knew everyone.

Back on the ward, I walked to Rodney's room, nervous but confident I would be able to keep it together. But it was empty, clean, waiting for the next troubled bushman to reluctantly contend with mortality.

Surely he hadn't died. Maybe he just got a bed in a nursing home. I ran through the likely causes of death – a massive thrombotic stroke, pulmonary embolism, or heart attack. He'd been clinically stable so recently. I felt panicked and guilty.

The computer housing the medical records was right there. If I accessed his record, it would answer my questions. But was that a breach of privacy? Probably, as I was no longer involved in his care and my interest at this point was surely personal. I wanted to know, but I stopped myself.

I felt a suffocating sense of failure, and shame, as I walked out into the bright hot day outside. The chicken nuggets were soaking their oil through the paper bag. I got in my car, turned on the radio and cried.

And although I have been a vegetarian for twelve years, I ate those six chicken nuggets. They were delicious.

—

Later I found out from a nurse that Rodney had been transferred to a high care nursing facility. For the remainder of my time in the town, I would check the local paper's obituaries, searching for his name, as a member of the public. But I never saw him there. Months later, I left the town, and I never saw him again.

—

I have thought a great deal about Rodney, and what he and his ilk mean to me.

Although Rodney did not ask me to be his friend, I felt strangely destined to be something more than a medical student to him and to people like him. I wanted to differentiate myself from the doctors who I viewed as providing an unacceptably low level of empathy and validation to patients. Yet my own need to be 'helpful' was a clear blind spot that could potentially justify a range of behaviour outside the scope of my role as a student.

When I told Rodney 'no worries' after his comments, and later when I bought him food, I was perpetuating a fantasy version of myself as someone who would be endlessly caring and giving to him – which I felt he needed. A friend, perhaps even a surrogate child figure who would listen to him and show him care and respect. Yet the persona I created for him was neither that of a friend, which involves mutual care, and nor was I his family. I don't know what would have happened if I did see him again, or how the chicken nuggets would have been received, but I think I could not have continued on playing this role indefinitely. At some point, if we had actually become friends, I would have needed to challenge his behaviour and beliefs, and this would

have exploded his image of me. I was not ready for the loss of power that would have entailed for me.

Shortly after the events of this story, I was introduced to the concept of transference and counter-transference during my first rotation in psychiatry. Immediately I recognised this dynamic at play with Rodney and felt a great relief. I could then recognise that Rodney meant something else to me, beyond who he was and what our relationship actually was. My feelings about him were not just personal, but perhaps reflected my experiences being a young woman around old men in the past. Onto Rodney, I'd projected my hopes of a mutual dynamic of respect and care with men. I understood on some level I felt responsible for showing him how to be around people – that he didn't have to live in rage, grief and isolation even if he was dying. With a frame to understand, I felt permitted to feel what I felt, and to explore and address these emotions.

When strong feelings of transference and countertransference are at play, and particularly when our patients are at vulnerable points in our lives, we risk creating dependence and attachments that can be painful for everyone. Many doctors deal with their own feelings of helplessness by blaming patients and becoming burnt out. This leads to worse care for patients, who are just as caught in the complexity of transference and countertransference as doctors are.

Now, I understand the desire to 'help' people, and to be liked and accepted by patients, is not a reliable moral compass or a professional standard. When we need to be needed and helpful, we can partake in a fraught dynamic that eventually leads us to view others as being more or less deserving of care, especially when we perceive them rejecting us, or our care-giving. We also risk the projection of our needs onto patients who simply do not have the capacity to meet them – and when we do this we subtly violate the trust necessary to the doctor-patient relationship. We must be willing to work with patients who may be complex, flawed, prejudiced and self-destructive, and to not diminish the care or respect we show them.

To do this work, we must recognise and accept our own emotions – however unpleasant, and however much we wish those emotions were not felt. When we detach from our emotions during emotional experiences, we are often at even greater risk of projection and judgement. I have seen this several times in hospital, where doctors under the guise of professionalism have ignored or shouted over patients who aren't fulfilling the role the doctor needs them to. Conversely, I have seen doctors whose rote learning of phrases like 'you seem upset', delivered tersely, can cause more harm than indifference. When we fail to understand ourselves, our projections and our counter-transference, we can perpetuate fraught dynamics of power that affect both patient and professional.

Now, when a patient makes me feel like I need to save them or teach them, I can breathe and think. It takes me a few minutes sometimes, but with practice I am getting better at sorting through what feelings are coming from who. I can notice the feelings of pain and rejection

coming from a patient, the frustration of a doctor, and my own sense of helplessness. An initial attempt at understanding creates a small pathway into reflection and depth. With time, I hope this will also allow me to speak up when I need to – not just to ensure my safety but also to challenge harmful beliefs, and to allow me to be more authentic with patients. It is a skill to do this without the patient (or doctor) feeling like care is being rescinded, but I believe it is possible.

Part of what Rodney taught me was letting go. What I see and know of the people I care for is only a small part of who they are. Respect for a person's selfhood and integrity means that I cannot, and should not try, to control their lives. When I admit my not-knowing, I can create a more honest and realistic connection with patients.

With this honesty comes the painful acceptance that I cannot single-handedly create a less abusive world, restore reparative relationships among family members, or lead angry men into reconciliation with their loneliness before they die.

Yet I am still living, and I have the capacity to at least try to understand myself and others. I am still a long way from accepting my limits, and from embodying the practical knowledge and wisdom needed to be a compassionate, professional and sane doctor. But as all my best teachers have shown me, medicine makes us students indefinitely, and there is nothing to be ashamed of in that.

*Name and other details have been changed

A Home Visit to Remember

Kevin Teo

Part I An unexpected first meeting

I grew up in a country where seasons do not exist, and cars do not sleep. There are more stars on our roads than in the heavens, and our horizon is like a piece of jigsaw – with the sky fitting snugly in between the crevices of juxtaposed skyscrapers. By contrast, facing a dilapidated barn house located at the end of many narrow, winding, icy country roads halfway across the globe, I felt very much out of my comfort zone. I began to have second thoughts on volunteering for this 'educational experience' as I traded a hot lunch in the comfort of the staff lounge for a nauseating car trip, the biting cold of the winter morning, and mud-spattered shoes. I could also tell that Dr. White, whom I accompanied on this domiciliary visit, was not fond of the journey. He bemoaned the state of his vehicle after it traversed mud and countless potholes along the way. Hammering the door handle thrice, I wished that my knocks were of sufficient intensity for our patient to become aware of our presence. After all, we were merely meant to deliver a course of antibiotics for him to continue recovering from bronchopneumonia, or so I thought.

We were received instead by Jillian, a petite lady with flowing silver hair and a mellifluous voice that could melt away hunger and chill. After exchanging pleasantries, she hastily led us across creaky floorboards and draughty corridors into the room where her husband lay. A gust of balmy air greeted us as we entered, owing to a crackling fire near where Roger was. In other circumstances, the ambience might have been fitting with the season of festivity, but the sight of Roger dampened all thoughts of seasonal cheer. He lay sprawled on the bed, flailing his arms around in a state of stupor, occasionally wrenched back into consciousness by paroxysms of coughing. He was febrile, tachycardic and severely hypoxic, with widespread coarse crepitations audible on auscultation of the lungs. As it turned out, Roger had persisted in that state for nearly a day, confined to his bed and refusing all food and drink. I hesitated after I examined Roger, glancing over at Dr. White for an inclination of how to proceed. From his furrowed brow and pursed lips, I could tell that he was taken aback by the scene before him. The room fell silent for a few moments as the trio of us stood before Roger, pensively trying to take it all in. Eventually, Jillian broke the ice, "he hasn't got much of a life left, has he?"

I felt as though she put us on the spot with her question – was it rhetorical or was she expecting a sliver of hope and reassurance? The ensuing silence was disconcerting, and I

resisted the burgeoning temptation to give Jillian what could potentially be a misleading answer. Our reticence must have made Jillian uneasy as well, and I could see her steel herself before continuing, "going into hospital is not an option. All I'm interested in is keeping him comfortable..."

"We're looking for a graceful end... not in an ambulance, not on a trolley in the hospital, but at home with family around him. We always hoped he would die at home and I think he would have liked that too."

After moments which seemed like an eternity to me, Dr. White responded, agreeing that the most appropriate course of action would be to start palliative treatment as the odds were stacked against Roger. I, however, did not share his sentiment.

"Does this involve a course of antibiotics? Do we do nothing?" I said, phrasing my protest as diplomatically as I could bear. Indeed, referencing a care plan made a few years ago, Roger did pen his preference to stay at home if possible and safe. However, he was willing to be admitted to hospital for treatment of acute or reversible illnesses. As Jillian put it, Roger had always been 'a fighter' and tenaciously sought to recover from any illness. Had Roger's goal been to live as long as possible, it should have been reasonable to transfer him to secondary care for resuscitation and intravenous antibiotics. Instead, what Jillian was asking of us seemed to be the equivalent of signing his death warrant, and I found it unsettling that we were planning to give up and do nothing for Roger, whose distress was conspicuous.

On reflection, what I observed was merely a snapshot of the disease process, whereas Jillian and Dr. White witnessed Roger's overall gradual decline from congestive cardiac failure. Every admission for an acute infection left him with a lower level of functioning than before, and Roger's dementia would always take a turn for the worse in the turbulent, clamorous and alien environment of secondary care. Judging from how I was overwhelmed, even as an observer, by the gravity of Roger's state, I came to understand and appreciate how difficult and painful it must have been for the family to decide that Roger would fare best in the familiarity and comfort of home despite being acutely unwell. All that it took was to put myself in the shoes of the patient and his family to realise that, despite having good intentions for requesting aggressive intervention, such an approach would have been counterproductive and prolonged Roger's suffering instead.

Part II Roger's hopes and wishes

Things progressed at breakneck speed and I returned to the barn house mere hours after I had first left. This time, I was with the district nurse to set up the syringe driver, with a completed DNACPR form in hand. I entered the musky room to find Roger unmoved, immobilised by his weight, staring blankly at the ceiling. He must have been aware of our arrival as he craned his head to signal his intentions to us:

"I can't get up. Help me sit up," he said in a raspy voice thick with secretions.

As we hoisted the stocky and rugged man to the side of the bed with great effort, what struck me was, ironically, how vulnerable he felt in my arms. After a few intense coughs to clear his throat, he flashed us a grin and professed, "one is recovering"

The somewhat half-hearted laugh that escaped my mouth belied the fact that Roger's statement shook me to my core. Perching myself by his side to clarify what he meant, he disclosed that he would like to recuperate completely to watch his granddaughter grow up, tend to the fraying state of his house, and (rather cheekily) to continue enjoying 'a good drink'. As he spoke, I felt concerned that we had been treating him as a depersonalised set of clinical signs instead of the impeccably groomed man in his chequered shirt who had dreams, hopes and fears. I fell silent, recalling that the decision to commence palliative care was made while talking over Roger when he could have well been aware of his surroundings. Was his silence taken for consent? Would he have wanted to be transferred to hospital for treatment of this potentially reversible infection? As the district nurse sited the continuous subcutaneous infusion in Roger's arm, I felt unnerved that the team had made an erroneous decision to start Roger on terminal care against his wishes. Nevertheless, all I could offer was a matter of fact yet slightly vague statement:

"We're giving you some medications to make you more comfortable and to help with your breathing," I said, feeling a pang of guilt. Somehow, I felt as though I abandoned one of the core tenets of ethics and medical professionalism – patient autonomy. Patients should have a right to know about their healthcare arrangements and those moments of lucidity were perhaps the only windows of opportunity for me to seek Roger's opinion on his care. However, I felt it wholly inappropriate to broach the topic of end-of-life care with him. Opting to inform him of his terminal state might have caused him unnecessary distress. On the contrary, despite yearning to do so, it would have been equally unkind of me to reassure him that things would be all right.

Thinking back, I might have misconstrued what Roger said to fit my preconceptions of his care. I desperately wanted him to feel better, and this made it all too easy to forget about the risks and sacrifices of aggressive medical intervention. By approaching Roger from a different frame of mind, one can distil his hopes into the key indices of quality of life at the terminal stage. Instead of aggressive treatment, a phone call to arrange for his granddaughter to visit, reassurance that the house would be maintained, a refreshing alcoholic beverage might have been all that was needed to maximise his quality of life in his final few days.

Several of the dilemmas that I faced regarding Roger's end-of-life care could have been avoided if he had a thorough discussion about his wishes and priorities at an earlier stage; however, gaps in communication are not uncommon. A survey by the Royal Australasian College of Physicians found that a third of patients were treated in a fashion that was incongruent with their wishes due, in part, to lapses in communication¹. Time constraints and the feeling that we have 'failed' to treat the patient are significant barriers impeding the initiation of end-of-

life discussions in secondary care. Furthermore, talking about impending mortality can be unpleasant and taboo for all involved parties, especially when it involves topics such as loss of function and pain. As such, it is common for medical students and junior doctors to shy away from these challenging conversations, leaving them instead to senior clinicians. However, in the process, we do patients, their families, and ourselves a significant disservice.

This experience brought home realisations that the responsibility to conduct advanced care planning should not be left for someone else to shoulder. Instead, doctors of all levels should strive to hold thorough discussions about health priorities and the boundaries of care with patients and their families. Although not immediately apparent, the outcomes of these conversations are of immense value down the line in navigating the complexities of terminal care in the community. Instead of relying on second-hand opinions of a patient's priorities, having a framework or knowledge of a patient's fears and hopes can help to ensure that his/her wishes are met to the very end. I am now more aware that multiple admissions and increasing frailty in non-cancer patients with life-limiting diseases (dementia, progressive cardiac or respiratory failure) foreshadow an imminent terminal illness and should prompt discussions about end-of-life care. Given the increasing global burden of non-communicable chronic disease and frailty, it is paramount that patients should have access to end-of-life care discussions to provide optimal care and to maintain patient dignity in their final moments.

Part III Compassion

On our way back to the surgery, the district nurse must have noticed that I was moist around the eyes as she broke off on a tangent during our conversation, "I sense that you're a compassionate individual, that's good."

"But do you feel that sometimes your compassion can work against you?"

I froze, wondering if she could read minds. While she prepared the syringe driver, I divided half my attention to watching her and the other to reassure Roger with my presence. Observing him in respiratory distress was becoming unbearable, and mentally I urged her on, impatient with her lagging efforts. Her words reminded me that there was a reason for her meticulous preparation: an error in the use of controlled drugs could have done more harm than good. Had I been preparing the medication, my undue haste might have created a ripe environment for mistakes to be made. To date, I safeguard her teaching for my future practice, that compassion to alleviate a patient's suffering can be a double-edged sword if the patient's safety is jeopardised in the process.

Her question would not cease to replay in my mind. The following day, Dr. White and I were scanning through the list of patients for the day over a cup of tea as per our routine when a specific patient caught our attention:

Jillian M.

Routine monthly follow-up

Without letting me in on the specifics, Dr. White seized this serendipitous opportunity to have me see her in the clinic. This time, Jillian greeted me with a similar wide-eyed expression as I displayed on our first encounter. As she directed herself to her chair, I found growing anxious and unsure of how to steer the consultation.

"I can only imagine how difficult it must be for the family during this period. Are you coping?" I asked.

In retrospect, I had merely been stating the obvious, and I was concerned that my attempt to venture into uncharted waters in what was supposed to be a medical consultation might have backfired. Instead, I found myself at a loss as Jillian began to weep, her voice harbouring her guilt and resignation. "I can't look after him anymore," she confessed between sobs.

"Roger is paying for his weight and drinking problem and so is everyone."

As Jillian assumed the role of being Roger's primary caregiver, she found herself sacrificing her hobbies, her physical health, and her mental well-being for him. Beyond the back spasms from her efforts to mobilise her overweight husband, their marital relationship had disintegrated due to Roger's affair with alcohol and his dementia.

"I've given up my life for him. And I know it's a terrible thing to say, but I can't be free until he is."

With the benefit of physical proximity, I noticed that her entire visage spoke of fatigue: from the frazzled ends of her flowing silver hair to her sunken eyelids and crestfallen lips. Even her stooped posture took an added level of significance – how could a kyphotic and elderly lady manage, when hoisting Roger was stretching my physical limits? Her disclosure rendered me speechless and on the brink of tears. On hindsight, I realise the helplessness that I felt might have come from resonance with her overwhelming sense of depersonalisation and loss. Normally, in secondary care, patients are given the limelight while caregivers assume an ancillary and collateral role. In this setting, I found myself in an uncomfortable position where I owed a duty of care to both Roger and Jillian and was uncertain of whom to prioritise. While brainstorming for a way to ameliorate Jillian's circumstances, I chanced upon the thought that perhaps we were doing the right thing by commencing Roger on palliative care. My thinking scared me. Would I have been swayed in favour of terminal care for Roger out of compassion for Jillian's predicament, running the risk of neglecting Roger's wishes and best interests?

"To cure sometimes, to relieve often, to comfort always," so goes the old saying. As I gained insight into the psychosocial aspects of Roger and Jillian's illness, I began to realise that not all problems raised by patients warrant a knee-jerk reaction to devise a concrete solution. On

hindsight, judging from the words of appreciation from Jillian as she left the consultation, it was evident that talking about her issues was empowering and cathartic for her, even if I could not offer her any resolution to her problems. Perhaps it was the same for Roger as he divulged his hopes and regrets while I sat next to him by the bedside. The complex emotions that I felt from being entrusted with such information served as a poignant reminder of the privilege of serving as healthcare professionals and the therapeutic power of empathy and listening in the doctor-patient relationship. It costs us not more than a few minutes of our time, but for patients who must grapple and cope with the psychological hardship of illness and disease, understanding and empathising with their difficulties can make a world of difference.

Part IV Burnout

Over two days, Roger's care arrangements had escalated from carers going in four times a day to an overnight Marie Curie nurse and 24-hour support by the Hospice at Home team. As encouraging as it was to witness the responsiveness of palliative care services to support the family during this rollercoaster journey, the emotional turmoil had taken its toll on me.

There was no time to stop and be melancholic. Steeling myself, I observed my duty towards my medical education. I saw other patients, maintaining a jovial front while I was, in truth, hurting deep inside. Inevitably, my sadness reached its tipping point and streamed down my cheeks behind the protection of closed doors. This happened thrice: after talking to Jillian in the morning, after observing Roger at death's door as the district nurse and I topped up his syringe driver, and after the news of Roger's passing shortly after. Over the course of the week, I noticed that I spaced out more frequently and started disengaging with my education; I began to care less for my patients. There was nothing pleasant about the state I was in. However, being self-aware yet unable to overcome my mental lassitude only compounded my frustration. Had I succumbed to compassion fatigue²? Did I make the mistake of becoming too emotionally attached to Roger and Jillian that I wound up exhausted, cynical, and devoid of enthusiasm?

Previously, I coped with the unexpected death of a patient whom I was very fond of by avoiding others, filtering out information, and bottling up my emotions. However, I realised that my detachment was counterproductive and might have resulted in inadequate care of other patients in the ward, had I been the doctor that was looking after them. As cliché as it sounds, time, adequate rest, and engaging in my hobbies helped me to recalibrate my focus this time. It was also surprisingly cathartic to review the events and my feelings with Dr. White, the district nurse, and my colleagues. I tend to keep my emotions to myself for fear of coming across as overly sentimental or sensitive in a profession which emphasises clinical detachment. What I had not realised was that sharing my vulnerability also helped others to voice out what they were feeling. Aside from being a lesson on the importance of social support and maintaining hobbies outside of work, I now appreciate that opening up emotionally is not weakness, but strength. When exposed to such situations as part of a clinical team in the future, sharing my

emotions and encouraging others to articulate theirs in debrief sessions would not only be mutually beneficial but also help to prevent burnout and its associated ramifications of poorer clinical care and increased medical errors³.

Part V Making a difference, even as a medical student

Several days later I arrived at the surgery on a particularly gloomy and frigid morning craving the warmth of a cup of tea before a long day of consultations. As I strolled into Dr. White's consulting room, carefully sipping on my drink, I noticed Dr. White pick up an envelope that had my name on it and waved it around in the air with excitement.

"Well done! It's not often that a patient writes a letter to a medical student." He said, beaming.

The day before, I delivered a handwritten condolence letter to Jillian for personal closure but also to thank the family for allowing me to observe and learn from their journey. After having come full circle, I considered it important to express solidarity with the family in their time of grieving, even though it was highly unlikely that we would ever cross paths again. A doctor-patient relationship that culminates after death and the signing of the death certificate misses the opportunity for continuity of care for the family and, in this particular case, to support Jillian's transition to independence.

In return, Jillian wrote back and encouraged me to continue learning from patients' stories and to "always carry with me, tucked away, my natural empathy" (Appendix). As a medical student, I had grown accustomed to feeling unhelpful, being side-lined and in the way. For Roger and Jillian, I was able to feel proud of the difference that I made: by investing time to provide a listening ear and to engage in collaborative decision-making with the family. Caring for patients and their families can be fraught with pitfalls and challenges, but investing our time to understand the patient's behind the disease can be immensely meaningful and rewarding in return. I sometimes worry that time pressures will inevitably limit the quality of care that I envision myself providing as a junior doctor. Nevertheless, I draw comfort that the skills that I have been taught and actively employed – active listening, empathy, and collaborative care – do not require much time at all. Clinicians who allow themselves to be moved by their patients enrich their own experience of doctoring⁴, and I hope that the tears that I shed, and the many more that I held back, would help me to be a more caring doctor to my patients in the future.

Epilogue

A year later and wiser, I find myself back in the city where seasons do not exist and cars do not sleep, giving back in small ways to the society in which I grew up. I still think about Roger, and I re-read Jillian's letter on the occasional evening when I feel utterly exhausted and

lacking motivation to carry on. I have also been thinking of ways to impart to others the valuable lessons which I have learned through my experiences with Roger and Jillian. One of the ways is to encourage and inspire medical students to take the initiative and participate in narrative medicine, experiential learning from patient's stories, and reflective practice.

My wish was granted one afternoon when I received a call from the intensive care unit informing me of a patient who was transferring to my ward for end-of-life care after being terminally extubated following a cardiac arrest. As I entered the cordon of fabric, my heartstrings twinged as I heard the rattling breaths of the middle-aged man and the mantras that his wife was chanting while kneeling by his side. She looked forlorn and beseeched me to stop his antibiotics and allow him to pass on comfortably, jolting my memory and making me flash back to the balmy room where I first met Roger and Jillian.

This time, I was accompanied by several budding medical students of my own as well as a resident nurse who observed from a distance. They maintained a respectful silence as I explained the palliative care plan and how we could collaboratively maximise his comfort as he deteriorates and developed agonal breathing and apnoeas. After the conversation, we huddled in the corridor where I addressed their questions on capacity and best interests. One of the students was particularly taciturn, his head slightly bent to obscure from view the tears welling up in his eyes. I tell him how heavyhearted I feel, prompting him to reveal that the patient's circumstances hit close to home - his mother had passed away from a similar illness not long ago. As we summed up what we collectively learned, there was unanimous agreement that there is always room for empathy, even when avenues of treatment are exhausted, for our patients, their families, and each other. I will not claim to come close to Roger's penchant for teaching which led to devotion of his entire career to educating others, but I do hope that he would be proud to know that his student is now a teacher, and that his story will continue to inspire many generations of medical practitioners to come.

*To protect the privacy of individuals, names and identifying details have been changed.

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Dear Kevin,
I and my family
cannot express adequately our
appreciation of your beautiful
and sensitive letter.

I'm sorry it came as a
shock to you, but I don't think
his life could have had a better
ending in the way it was
managed.

I hope you do well in
whichever branch of medicine
you go into and always carry
with you, tucked away, your
natural empathy.

would have been pleased
also that our situation was
perhaps a valuable experience
for you.

It has been a pleasure to
to talk to you. Good luck.

Cap. 09

**Papers not Delivered in
Congress**

An Inter-Fenestration: How the Sounds of Words Frame What We Hear (and See) and How They Frame Us

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Abstract

I use the story of a three way consultation in which, we all three are wrestling with what we are each seeing and find ourselves playing with this not quite knowing.

Within the shared poetry of the three way consultation appears the birth of archetypal meaning, the symbolism of masculine and feminine, an insight into what it is to joust and penetrate another person's worldview as well as become the muse for holding and containing the different vistas we bring to the world.

It is also a story of the trickster doctor who is out played. Through this lived experience we will explore the conundrum of translating a Portuguese poem. I invite us to explore again our not knowing through the window of words, both foreign and native.

I am reminded as I write, that Balint worked in England in his third language. What was that like for him?

Introduction

I am going to start with a story of a consultation where I was out played. I was outplayed beautifully and exceptionally. The dance that emerged was both intimate and direct and had a whimsical poetry to it from which I continue to draw sustenance.

We will then draw on a famous Portuguese poem to explore the nature of our personas and how we play or joust with our own inquiry inner and outer regarding what is real and what it not.

Story

I am working in an area of Manchester called Moss Side. It is called Moss Side because Manchester is rather wet city on a plateau in North West England. And once upon a time the wondering serpentine river Mersey flowed close to the area on its way out to the Irish Sea. So once, it was indeed a fertile, boggy and mossy place.

A daughter and a mother attend for a consultation. We walk down the long corridor to the consulting room together, and the mother and daughter go into the room first. The daughter sits beside the desk and The Mother next to her. They are dressed in the traditional garb of the hijab, which is tightly clasped under their chins. This way the material is bound closely over their heads. They look like two angels, like you might see in an orthodox or catholic icon painting. The consultation is the mother's and she has sat further away from me, which is already interesting. They are Somali and the daughter is interpreting. I have met The Mother once before and know a little of her story, of her journey from dry Somalia to wet Manchester. The Mother is in her mid 60s and the daughter is just 40.

About half way through the consultation. The Mother asks, through the daughter, 'why are you so smiley?' I am very surprised by this. No one has ever asked me such a question before, let alone in a consultation. In fact, I find myself somewhat lost for words. I have a fleeting thought about her; is The Mother disinhibited in some way but it doesn't fit the picture and she seems to be asking the question through her daughter in such a warm way.

So I sit there in my chair and I breathe. Eventually I have the presence of mind to turn it back on her, at least that is what I thought I was doing. I say, well perhaps I am smiling for the same reason that you have such a wonderful sparkle in your eye. The daughter is translating remember and at the same time she the daughter starts to nod her head. Slowly and deeply she is nodding her head. Now, I really am not sure what is going on. I can't remember what the consultation is about and I've been asked this rather penetrating question. My response seems to have been well met and the action seems to be in my court still. With the nodding, I guess I feel encouraged to carry on.

And so I do, carry on. I say, perhaps, the journey of your leaving Mogadishu; and your ending up in the Dadaab camps in Kenya; and being their for over 10 years; and despite that, your find a way to bring up 7 children; and then you all coming to Manchester, which is a very foreign and damp place compared to East Africa, perhaps it's because you know about suffering.

The daughter who had been nodding here throughout, stopped. And I stopped. There was silence. And then, in the most perfect English the Mother said, 'yes we are all one.' Yes we are all one.

Why are you so smiley. Yes, we are all one.

Was I moved by the experience? Yes. Did her words penetrate me and I mean that in a symbolically masculine way? Absolutely. Did I feel held and engaged and fed in that symbolically feminine way that only the feminine can do. Yes?

I have heard those words said many times and glanced over them as if they were some pretty rhetoric. This time the words went deep in side me, an invitation to dance

An invitation to celebration our cross cultural, cross language cross gender mytho- poetic selves.

So what has this got to do with Portuguese poetry you might ask?

Well, Fernando Pessoa whose surname means persona, wrote extra-ordinary poetry and wrote literally from the perspective of many different personas. These personas even had different names and different styles of writing, which he played with purposefully. Many of his poems are also metapoems by which I mean poems about poetry. Perhaps this is not so different a frame for a Balint conference, where we were use the frame of Balint to reflect on the Balint frame.

Just to add to the complexity, Pessoa's poems are very hard to translate, not because there is any right or wrong way but rather because his writing is so rich with metaphorical language. He is playfully and generously inviting us to see the world through the lens of many levels of meaning, perhaps not so different from Balint. In regards to metaphor and language, I think Gaston Bachelard puts it beautifully, 'The image has touched the depths before it moves the surface.'

So, how better to explore the nature of not knowing than through a poem by Pessoa, It's called psychographia? For me it's a poem about how we venture into that playful metaphorical place, where in that journey of being empathic to another we can get to try on what it feels like from another persons perspective and then hopeful (or maybe hopefully not) return back to ourselves.

In its latin original fingidor has a number of meanings; compose, create, invent, devise, contrive, imagine mold, form, shape. Is this not what we are doing in our work, in our balint groups and also here.

We will hear it first in Portuguese and then in English

*O poeta é um fingidor.
Finge tão completamente
Que chega a fingir que é dor
A dor que deveras sente.*

*E os que lêem o que escreve,
Na dor lida sentem bem,
Não as duas que ele teve,
Mas só que éles não têm.*

*E assim nas calhas de roda
Gira, a entreter a razão
Ésse comboio de corda
Que se chama o coração*

*The poet is simply a player
A player that is so complete
that he can all but pretend, what is pain.
Pretending pain, that, is quite a feat.*

*So when you walk into his play,
no pain is felt; true or false?
'cept the two that you have yourself,
Is this fake? Of course (no), of course!*

*So, in the steps of words and flow
Finding reason for all to enjoy
in accompanying those in the know
p'rhaps best our hearts we employ*

In its latin original fingidor has a number of meanings; compose, create, invent, devise, contrive, imagine mold, form, shape. Is this not what we are doing in our work, in our balint groups and also here.

The extraordinary thing about learning a poem in a language you do not know is that the poem and the poet gets under your skin in ways you could not imagine. Auden suggestion that the poem reads us¹. Could this be similar to our patients reading us?

How was I read by the patient? How does this poem read me?

Questions and Reflections

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Seeing the Doctor Patient Relationship Through Other Eyes With Balint Concepts From The Basic Fault to Triangulation and Creativity

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Abstract

Thinking of the theme of the conference, two strong feelings came to my mind. "Seeing through other eyes" might be a strong motto for the contribution Balint has made to my experience as a GP and Balint leader. Discovering Balint concepts was a path rich in encounters and opportunities to share other colleagues' eyes on these concepts.

The key ideas I keep in mind from Balint's concepts are the "basic fault", "primary love", "area of creativity", and a change of perspective from basic fault level to oedipal level, with specific clinical elements and ways of communicating with a patient.

This made me realize the importance of supporting an evolution from a dual relationship, to the consideration of a triangulation of the doctor patient relationship and the Balint group, to help find more colorful perspectives to confused situations. Isn't triangulation the conceptual side of any experience of "seeing through other eyes"?

Text

Thinking of the theme of the conference, two strong feelings came to my mind.

First "seeing through other eyes" might be a strong idea for the contribution Balint has made to my experience as a GP and a Balint leader.

Then discovering Balint concepts was a path rich in multiple encounters and opportunities to share other colleagues' eyes.

The key ideas I would keep in mind from Balint to help me see "through other eyes" are the idea of "basic fault", "primary love", "area of creativity" and a change of perspective from basic

fault level, to oedipal level, equivalent to an evolution from an exclusive dual relationship, to triangulation with the Balint group.

Lastly I will share how these concepts support a constructive dynamic of "seeing through other eyes" which may have helped me find new perspectives in a doctor patient relationship, and how as a group leader they may have helped the group to find a more colorful vision of a confused situation.

Like most care professionals I discovered the dynamic of Balint groups as a participant and Balint concepts through the eyes of Balint leaders I met.

I was fascinated by the group process. Seeing how new perspectives could emerge within the group. How the presenter, fostered by the multiple ideas of the participants and the confidence built, might say close to the end of a session: "I forgot to tell you this". Usually bringing new perspectives to a blocked one-sided situation.

I had the chance to discover with my mentor, Louis Velluet, the simplicity of Balint psychotherapy concepts from the book *Basic Fault*¹, and how they could open a dynamic and hopeful perspective to the doctor patient relationship.

- The idea of *primary love* describes the ideal atmosphere of the early mother child relationship. I understood that ideal atmosphere could inspire the doctor to develop an atmosphere to help contain a patient in a regression stage.
- The idea of *Basic fault level*, translated in French as a "fundamental defect", supports the idea that a damage in early development of a person might work as a "defect" or "injury" in his/her construction and ability to adapt in his/her social development. That idea helped me develop an interest in the patient's history to be understood as a process.
- The idea of an *area of creativity*, describes how "suffering patients, after a stage of depression, may recreate objects that help bringing to livable solutions". I was surprised by Balint's idea that creativity might imply artistic creativity, as well as some symptoms, as an expression or way out of unspoken sufferings.¹

I had the chance to discover Balint concepts, and experience Balint group leading along a path sharing views with Balint colleagues, and how they would see Balint concepts through their own eyes.

- Louis Velluet gave me a simple and creative perception of Balint concepts. To him Primary love, Basic fault, and the dynamic of a creativity space were not heavy words to be left to specialists, but lively concepts that could highlight an understanding of our patients through their history, and help the doctor see his encounter with a

patient as a dynamic experience and opportunity to reinvent his path within a caring and creative atmosphere, as "good enough parents" following Winnicot's words. He gave me the idea, which he had heard from Enid Balint, that Balint had in mind to alleviate the burden of responsibility on the doctor's shoulders.

- Meeting with Andrew and Penny Elder helped me hear more of Enid Balint's contribution to Balint's work and ideas, and that what we consider as Michael Balint's work was more of a Balint contribution as a couple. Andrew Elder's speech in Warsaw⁴ was a strong testimony of a lifelong professional experience as a leader, gathering key elements in the dynamic of Balint group leadership.
- These meetings and readings, helped me think of the parallel process in Balint group leading as a way to come out of a dual perception of the doctor patient relationship and black and white ideas. Bringing through the eyes of the participants, new ideas that could bring creativity to the situation presented.
- Leading Balint groups helped me experience how new ideas would come out and the group would sometimes bring to a case a multiple vision of a situation, reminiscent of the polyphony of an orchestra.

All these encounters and experiences have helped me see Michael and Enid Balint's ideas through personal and experienced eyes.

Within that path I recently had the chance to rediscover the *Basic Fault* in English, with new eyes. I was struck by the simplicity with which he described the four following concepts, with words full of metaphors.

- *Primary love*, was proposed as a theory of primary relationship to the environment, quoting the *Harmonius interpenetrating mix up* between foetus and mother. It was described as a Primary object relationship, with the nature of the *primitive two person relationship*. Balint considered that the analyst had to assume the qualities of a primary object in some phases of a satisfactory treatment.
- The idea of a *Basic fault* would have been suggested to him by the words of some of his patients, feeling they had a *fault*, and feeling something missing in them since their early stages that had to be repaired. Talking with Jane Dammers, about the meanings of "basic fault" in english, I heard that it can describe a "geological fault in a rock formation – a displacement or shearing of the rock". I felt this image is a strong metaphor of a failure within the early foundations of a person. This was consistent with the idea of unspoken damage that could not be described with speech. This brought a new perspective to my understanding of 'basic fault', compared to the french translation of a "fundamental defect".

- In the chapter *the two levels of analytical work*, quoting the "confusion of Tongues between the Child and the Adults" of Ferenczi, Balint describes a difference of communication between patients who are accessible to adult language and interpretations referring to the oedipal level, and those patients who require a communication adapted to a preverbal level, which can be more difficult to handle. Balint calls it *the Level of Basic fault*, defined as "a simpler and more primitive level than the oedipal level". It is characterized by "an exclusive *two person relationship*, of a particular nature, with dynamic forces different from conflict, and acting. With these patients adult language is useless or misleading". He describes a contrast with *the oedipal level*, which "happens in a *triangular relationship*, with at least two objects apart from the subject within a level which is inseparable from conflict created by ambivalence". With these patients adult language is an adequate mean of communication.
- Balint describes a third level as *area of Creation*, with no external object: "the subject is on his own, and his main concern is to produce something out of himself". This may be an object, such as in artistic creation, or other phenomena, among them mathematics, philosophy, gaining insight... And last but not least, the early phases of becoming "ill" and spontaneous recovery from an "illness".

In my practice, these four concepts are strong tools to view a situation with a specific eye, looking for a close understanding of the person's history and identifying the proper level of communication, with an attention to the dynamic and creativity within the relationship.

I bear in mind the idea of a Basic fault as a structural failure that may explain the difficulty in communicating with highly suffering patients. The idea of primary love may inspire an atmosphere to help contain suffering patients, and the idea of looking for creative ideas may help to find opening doors after phases of regression.

A new perspective is embodied in the idea of a different communication with a patient moving from a dual and exclusive relationship, to the possibility of accessing triangulation.

Some difficult doctor patients situations may be sorted out by considering different levels of communication, non verbal and verbal communication. Sometimes supporting an evolution from a dual and demanding relationship to the introduction of some triangulation may help the patient and the presenter to develop a more creative relationship, one which is more lively through others' eyes.

As an illustration Miss R came one day to my practice, just arriving from a region in the mountains. She described in very pressured speech how she fell into a depression, isolated in a mountain village and taking care of her two kids, after leaving her job as a journalist in Paris to follow her partner - "the love of her life". She was supposed to be happy and did not make it. At the first meeting I felt her anxiety, an inner agitation and a lack of self-confidence. The

subsequent consultations were in different tones.

There were definitely two levels of communication with her. Sometimes a rational adult speech, when speaking of her history, her plans and her family. Whenever sickness was around her kids, she would seem desperate and confused again, acting in the consultation room with agitation, unable to calm down her kids.

She definitely made me think of basic fault level when she was confused, required close attention and motherly reassurance from the doctor.

The idea of a lack of support in her early childhood was confirmed when she told me her mother had barely raised her and left her to her grandmother. This was still present in the feeling of guilt and self-pity she had, her mother criticizing her for coming so often to the doctor when her kids were sick, instead of taking care of themselves on her own. This seemed a clear lack of support from her own mother, undermining her instead of offering help.

Seeing her situation through Balint concepts helped me to understand her, and to develop, as much as I could, an understanding attitude and atmosphere in the consultation and a holding position. This helped her feel reassured and restored some of her self-confidence.

A global aim was not to stick to a high demanding dual relationship, but to help her to find out what other support she could rely on. She referred to her grand mother, who motivated her moving here, as well as her partner and kids.

Taking care of her required a combination of close support when she was in a regressive attitude, and a more open speech when she was accessible to rational language, referring to the people supporting her, and have her talk about her projects and plans to find a job and develop her creativity again.

In a last phase I had to support her in the family plan to move back to a bigger city in the mountains when her partner had a professional opportunity. Fear invaded her body language again, requiring a strong physical presence to help her calm down, including a firm and comforting tone. Once she felt more secure, I helped her to get out of the loneliness of her fear and be confident in the human supports she would have.

One of the aims of the doctor patient relationship was to help her see through other eyes, helping her get out of the fear, loneliness and self deprecation which brought her back to the lack of support within the dual relationship to her mother. Helping her develop triangulation, getting confident in the people supporting her and to see through the lens of her actual life.

As for an illustration of the importance of triangulation in Balint group leading, I will share with you a situation presented by an experienced GP. She was used to listening to her patients and supporting depressed patients when needed, and a regular participant of our monthly

Balint group. She once talked about a man who caught her attention because she feared he might commit suicide, he being unable to get out of depression after the suicide of his son.

The first half of the Balint group was full of difficult emotions, when she shared with the group how the son was suffering from a psychotic illness, with paranoid ideas and had gradually lost contact with almost everyone. The father seemed to be the last one to come regularly to his son's place, and expressed his guilt of being alive while his son was dead. The father gave little information about his own history.

The Doctor seemed stuck in a close relationship to the patient, describing how she felt inefficient in helping him, while letting him stay for long consultations at the end of her working day. Her motive seemed the fear of him committing suicide as his son did. As a parallel process, the doctor seemed stuck in a dual relationship with the patient, invaded by his fears and emotions, with very poor information on the patient's own history.

Presenting the case in the Balint group was equivalent to bringing a triangulation to the situation while the group highlighted that symbiosis between the presenter's fears and those of the patient. Listening to her story with other ears, helped the members of the group see the situation with other eyes, highlighting that the patient seemed to have a different psychological structure from his son, and seemed to be able to create a strong and demanding relationship with the GP. Members of the group could feel the strength of the relationship for the patient, and share alternative views to help the GP see the situation from a distance. Pointing out the possible parallel process between the guilt of the patient, and some of the guilt expressed by the doctor, was a "mirror effect" visible through the participants' eyes.

The triangulation brought by the group work seemed to help the doctor see the situation through other eyes, helping her breathe again and feel less trapped in an initially dual relationship, in response to the burden of the patient's intense suffering.

This highlights one of the contributions of a Balint group which is to give access to a space of triangulation thereby "seeing through many other eyes".

Overall, seeing through other eyes could be a strong motif for one of the main contributions of a Balint group process to a doctor patient relationship. Most of the time it enables the participant to get some distance from a dual relationship which might be perceived as confusing, to the polyphony of a Balint group, bringing a multiple triangulation perspective.

The parallel process that can be described when leading a group, translated in French as the "mirror effect" of the group, can be described as "bringing many other eyes" to a situation, and if I may use the metaphor, moving from a duo to the polyphony of an orchestra, bringing a more human and enriched perspective to a one sided doctor patient situation.

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The Efficiency of the Balint Group Process in Case of Traumatic or Psychotic Structural Dissociation

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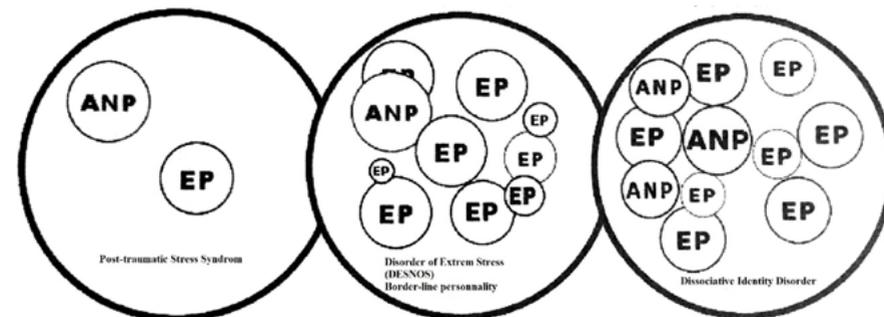
Abstract

The Balint group disposition has been thought by psychiatrists in contact with psychotrauma. Our actual knowledge about the neurophysiology of the trauma, the role of certain hormones and cerebral structures like amygdala and hippocampus, the theory of trauma-driven structural dissociation of the personality, the existence of an apparently normal personality (ANP) and a dissociated emotional personality (EP) in the PTSD can help us to see with other eyes the efficiency of the Balint group process in case of traumatic or psychotic structural dissociation

The Efficiency of the Balint Group Process in Case of Traumatic or Psychotic Structural Dissociation

Fifty years after the publication of the article of Michael Balint about trauma, our actual knowledge about post-traumatic stress syndrome (PTSD) can let us understand better what we observe during the animation of a Balint group when, unconsciously or not, one participant presents a case where a structural dissociation is present.

According to the theory of trauma-driven structural dissociation of the personality, the primary configuration in PTSD and complex dissociative disorders is the existence of an apparently normal personality (ANP) and a dissociated emotional personality (EP). The ANP maintains executive control most of the time and carries out daily adult functions. The EP spends most of its time not in executive control, but takes over intermittently when there is a switch of executive control, which occurs in dissociative identity disorder (DID) during periods for which the ANP has amnesia. In PTSD, the EP can take full executive control during a flashback in which orientation to the present is lost, and the person is in a full reliving of prior trauma. An EP is a psychological structure that is a separate, dissociated biopsychosocial subsystem of the whole person, with its own sense of subjective selfhood.



The EP holds the feelings and memories of the trauma and the mammalian defensive reactions related to it, including fight, flight, and freeze or tonic immobility. Rather than full switches of executive control between the EP and ANP, there can be intrusions into the ANP from the EP.

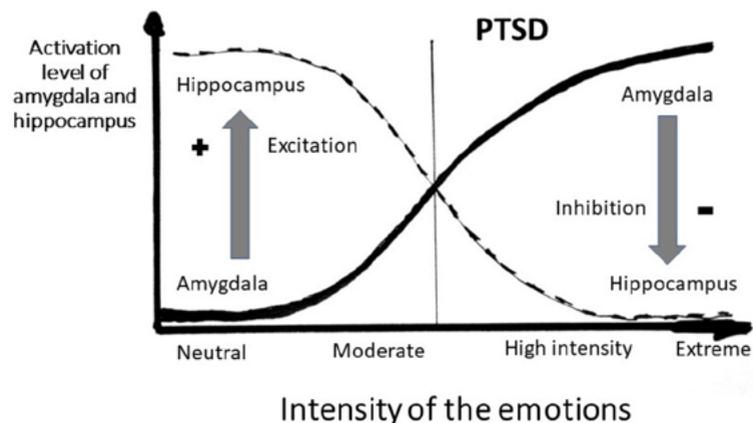
Such intrusions can include thoughts, feelings, memories, partial motor control, or any other psychic phenomenon. Inversely, there can be withdrawals out of the ANP into the EP, resulting in amnesia, conversion symptoms, numbing and related symptoms.

Violence, especially that which is most unrepresentable, exercised under the cover of love, education, sexuality, such as intra-family and sexual violence, has a psychic effect which will paralyze the victim, prevent him from responding appropriately, and prevent the cerebral cortex from controlling the intensity of the stress reaction and its production of adrenaline and cortisol. Extreme stress, a real emotional storm, can invade the body and - because it represents a vital risk for the body by attacking the heart and brain by excess of adrenaline and cortisol- triggers neurobiological mechanisms of safeguarding that breaks the emotional circuit and leads to emotional and physical anesthesia by producing morphine and ketamine- like « hard drugs ».

They are antagonists of N methyl D aspartate receptors who, by hyperstimulation, are able to disconnect the limbic system from the cingular cortex, stopping the contextualisation of the event, reinforcing the inscription of the traumatic memories and producing cerebral neurotoxic lesions. The emotional anesthesia generates a dissociative state with a feeling of strangeness, disconnection and depersonalization, as if the victim became a spectator of the situation perceiving it without emotion.

But this disjunction isolates the structure responsible for sensory and emotional responses (the amygdala) from the hippocampus (a kind of software that manages memory and temporo-spatial identification, indispensable to make a memory be memorized, remembered or temporalized). If the hippocampus can not do its job of encoding and storing the sensory and emotional memory of violence, it remains trapped in the amygdala without being treated, or transformed into autobiographical memory. It will remain out of time, non-conscious, identically... It can so invade the field of consciousness and let relive the hallucinatory scene again, like a

machine to go back in time, with the same sensations, the same pains, the same sentences heard, the same smells, the same feelings of distress and terror (flashbacks, reminiscences, nightmares, panic attacks ...). That memory trapped in the amygdala, not becoming autobiographical, is called traumatic memory.

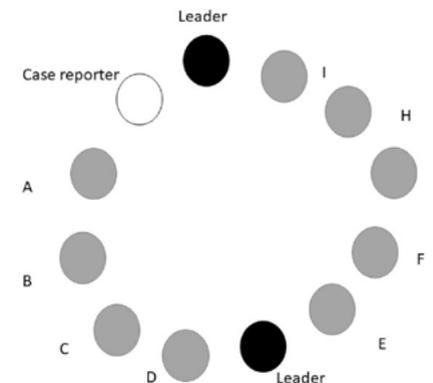


Normally, the memory can inscribe an image, a context and an emotion together. In case of hyperstimulation of the amygdala (fear), hippocampus is inhibited and only the emotions are inscribed in the memory. This possibility appears sometimes in a Balint group when someone is suddenly invaded by an emotion and can't say nothing about it. Most often it is a contact with a traumatic memory.

Sandor Ferenczy, John Rickman and Wilfred Bion were military doctors and had contact with various war traumatized soldiers. They had to identify the true victims from the false and were sometimes associated in the selection of the officers. This experience with one of the hardest human experience surely had an influence on their theory. Michael Balint also has been soldier and knew the reality of the battlefields. He was confronted to the suicide of his parents, the expected death of his wife Alice suffering of an aneurysm and to the question of identity. He changed his name, his religion, his country, his position, his couple,.... He crossed over a depressive period without words and scientific production...

The Balint group is organized as an container of psychic fragments. Ideally two leaders, a man and one woman, try to understand the dynamics of the group, their developmental stage, how to intervene and the consequences of interventions. It is only when the group process can be seen more clearly that the ways in which it parallels the case presentation can be used to illuminate the doctor patient relationship. The presentator reports a case, a clinical situation, a real fragment of a doctor patient (or a caregiver patient) relationship difficulty. The other members of the group are closing a circular disposition, an envelope bringing together

Balint group disposition



a multiplicity of identities, fragments from each participants but not recognized in an appropriation allowing a qualification and an identification. The group allows in a first time to welcome, as in a bag, these bits of body, of heterogeneous identities. This container fulfills an essential function of conservation.

In the course of the session, a process of sorting, separation can be done through interpretations, allowing everyone to own a part of the case presented. The body envelope of the group acts as a container with the support of the look and the listening of each one. This will allow access to an lightly modified experience of the relationship.

An illustration : the presentator, a woman, speaks about a old woman of 90 years having a dementia but still leaving alone. She opens her door "to everyone", to all the tramps of the street but she can let her door closed for her doctor. She has money to pay the hairdresser but not enough for the doctor. When she finally opens her door to the doctor, she speaks endless, fulling the conversation with repetitive sentences, with social automatisms and with events of her past or news of her dog. She ensnares the doctor who became passive and doesn't speak more about the dirtiness of her clothes, the oedema of her right arm and of her legs... If the doctor speaks about disease, the communication is broken. The apostolic function of the caregiver is powerless...

Participant A will say : I'm angry at this woman who mistreats you.

Participant C will say : Is she in danger? Can we ask the police to bring her to the hospital?

Participant E, in front of the case presentator, will say : She abuses of your patience. She don't

let you be a doctor.

Participants F and G are mute. Paralyzed like the doctor? Frozen by an impossibility to think?

Participant I will say : She not opens her door to everyone. Just the tramps and the hairdresser... Those persons will not speak about her disease and degradation...

The leaders see that the presentator often comes with similar cases of passivity and inability to take her place as doctor... In the debriefing they have the hypothesis that she was sexually abused in her young time...

Every participant has taken a part of the situation. The anger, the temptation to impose the doctor power, the possibility to be abused, the frozen attitude of the victim of a trauma, the incapacity to think... The leaders and the interpretations of the group can give those fragments a name and an identity and perhaps try a unified hypothesis.

In another example. Presentator is an old doctor who often takes so much time to present the case that the group work is reduced. He repetitively presents cases where he chooses to be illegal in order to help a patient. He has no question for the group but hopes to receive the approbation and the congratulations of the group. The group reacts expressing its frustration, its castration and its impression to be utilized. Participant F will say clearly : I have the intuition that you are afraid of the reaction of the group and you try to hold it mute. Then the presentator made a confidence : when he was young and he dared to speak at table, his father sent him a knife.

Conclusion

The alpha and beta elements of Bion can be completed by our knowledges about traumatism and structural dissociation of the personality. The disposition of a Balint group can help the emergence of past or recent dissociation in the patient and in the caregiver also. Time for working together takes here a great importance.

Some Conditions for the Success of a Balint Group

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Abstract

Some conditions for the success of a Balint group

The first one is to see what allows a development, which is for the group to be kind without protecting from the risk that every consensus can weight on each one's creativity. It exists between the two a form of paradox which is better to accept than try to shrink.

The second is that the way of a certain guilt from the therapist in front of the numerous difficulties of their practice can thanks to the Balint group change into a new knowledge, a fertile development.

On this path, questions and advice given can help as much as they can disturb this Balint process, it is something that needs questioning.

This allows, with other parameters, the enjoyable run of a Balint group and participate to help the therapist in a more comfortable practice, which is the first goal of the Balint practice.

Some Conditions for the Success of a Balint Group

Behind what a Balint group adds to the clinical practice, different aspects are found participating to the success of this process.

The group as a support.

To be supported, comforted and validated by a group is often times necessary but can also be hazardous: Groucho Marx said that never would he be part of a group that would welcome him as a member!

We can hardly express better the paradox constantly existing between the very human

desire of being comforted by a group and the inherently narcissistic, moral and superegotic linked to it and the lawful desire to stay oneself. Both aspects are at the same time dependent from each other and autonomous. It's impossible for the human being to discover themselves without the others while not being able to be themselves without some form of conflict with the others.

That inevitable paradox, when it is understood and accepted by the leader, allows for tolerance and kindness within the group's functioning without looking to repress too strictly what seems to not fit into the rules. Those also need to be in a state of dialogue with what pushes them instead of trying to impose themselves too violently. A decreed rule is often a rule that can't be explained...

When it is heard this way, conflict seems less violent for everybody as it testifies of a helpful process of salutary differentiation and exchange of more meaningful and deeper stories.

A quick example of this contradictory process: in a short-lived group, a leader participant express a difficult they have with one of their groups, where one of the members sometimes takes an invasive place making the flowing functioning of the group hard. It happens that this member is also the one who invites the others as it happens on their workplace. It is undeniable that if the development of this short-lived group had stopped there, wholly invalidating the leader's experiences who reported this case, this sequence's conclusion would have been entirely superegotic, even authoritarian. Thankfully the group got through this rule's stiffness to dig deeper into the historical specificities explain its functioning and the development could peacefully continue.

The work on guilt

The other aspect mustered by the group, far from being the least important, is linked to the question of guilt. This is the result of a fault involving a damage, be it imaginary or not, caused to someone else no matter the nature of this fault, had it been wanted, unconscious or unavoidable. As a choir in ancient Greek tragedies which function is to continuously bring back a character's dilemma to the city's justice, guilt sings us a melody that wants to close the debate on the other's side, of moral, of said city.

A Balint group's goal is here different, in a way comparable to psychoanalysis: it is, from this wall of guilt, impression of a fault or symptom in the analysis to allow the resumption of a story's run, or stories', that is to say the stories of who is exposing themselves, who is exposed and the participants.

It is important to point out a parental link between this function of suspension of the judgment allowing the continuation of a development and the psychoanalysis' free association rule that pushed to let thinking flow independently from any moral judgment on what has been said.

Of course superego, rules, moral judgments are ingredients that no society could let go off. But a lot of societies also suffer from a certain amount of difficulties caused by rules that don't take what reality show them into account: rules themselves need to keep an open ear...

An example coming once again from a group: a member of the group wants to talk about a case that put her in an unstable position. In fact, this child she accepted to work with doesn't correspond to her "official" competence, let's say psycho-motor specialized speech therapist or something else... Furthermore, she doesn't do anything with them as they carefully sabotage all her instructions. A somewhat strong guilt sprung from there that took her to talk about it during a Balint group. The proceedings of a Balint session on this case, far from any moral judgment on the fundamental moral goodness of such a practice allowed to show all the good that this specific practice of a lack of pressure, demands and this simple human presence exempt from expectations did to this child in reality overly requested for the performance that were expected from them by both family and school. This was only allowed by the flexibility of this person's professional rules who learned that sometimes guilt can be a teacher when the depth of stories and instincts of one another are let to unravel.

Questions in question

As Michael Balint¹ said, if we ask questions we'll get answers and nothing else!! However, the use of questions as everyone knows and sees, is at the center of the balintian process. The development of a session is based at the same time on a story and the reactions caused by the questions offered by the participants. In fact, we can make an analogy between the story which would be the narrator's conscious plane and the questions oscillating between pure projections of the participants or opening on the unconscious at play in the story. Between the two is located what we call the group dynamic, which is the more or less conscious feeling of the unconscious elements at play in the story. Then the leader, first withdrawn during this time of development through questions, can little by little enter in the depth of the case thanks to the story and remarks of the group, especially if he has a formation on the group dynamic to begin with. There is however that should never be forgotten: a question is always an intrusion of the thinking process and can in that case create as many good things as it can cause damages...

In the previously quoted book by Michael Balint, countless are the reproaches he does to doctors who are too upfront with their patient, overly quick in their own reflections. The resistances created often block the therapeutic process.

Thereby, if they enrich the case's story, if they help unveiling layers hidden until then, questions divert the aim, orienting the reflections in directions that makes us uncertain if they belong to the psycho-therapeutic that was brought up if there are too many of them or they're too insistent. In this case, we only obtain answers and not the useful deepening of the story anymore.

Too many questions or a too important insistence can move the group dynamic in insidious ways from the case's story to the problematic of those who question it without always realizing it on time. The object of the Balint itself changes and instead of being to any use to whoever decided to tell the case's story, it becomes a place of reflection for those who ask the questions...

It is all a question of moderation, knowing that question can shine a light on a case as much as make it foggier! The leader's art is to attempt to unravel this as best as they can, to save a group dynamic that still serves the therapeutic transfer brought to the group.

Let's illustrate this: thus during this session the case, a paranoid closure in a rural isolation will remind a doctor of the group a similar experience still vivid in their memory bringing them to ask lots of really passionate questions and remarks. In fact, the questions they're asking always bring back to their own experience instead of being relevant to the current case. The group would only get its dynamic back when the offer to go back to this story would have been made in a later session, which it will do, but this time in an appropriate mindset, the group clearly serving the doctor's questioning in this later step.

In reality, this confusing aspect of the flow of question coming to enrich the developing story is inevitable. The only thing that could prevent too many drifts is in that case knowledge which allows to not take literally all those questions to simply witness their effect, enriching or confusing depending on the case.

Advice

It is a subject often debated in balintian places. While some think that because of their formation they are legitimate in giving advice in a group or individual setting of the art of psychotherapy or psychoanalysis, others think it limits the precious risk-taking capacity in the run of a psychotherapy and therefore any advice restrains the therapist's creativity, mandatory to their job. But what is an advice? In the most simple cases, it is a technical advice from someone who possesses a bit of knowledge that the other doesn't have. But even in the most simple cases, it isn't that simple... Let's imagine that I am having a hard time with this gas pump with a vacuum valve that equips the carburetor of this Solex that I am renovating for my own enjoyment. It's been a week that I am on it and it does work for me. A friend to whom I have not asked anything comes and explains to me that it is the membrane's flexibility that is flawed even if it is not pierced... He is certainly right but at the same time he takes away the enjoyment of searching by myself without me asking anything! Nothing really important you'll tell me but even then... If this friend does this each time he comes with every problem in a house or in life, he will quick become insufferable! It is that the energy and passion we put to find a solution to our problems matter sometimes more than the solutions in themselves, which are more priceless when they are ours.

It is truly that dynamic process of the psychic life, this research, those developments, those

unresolved difficulties that make life worth living.

Thus can we differentiate two types of advice: those that are given and those that are asked for. In general, the first ones are really risky with the second ones are better received. It is that the advice, the technical competence can only work with a real desire to learn coming from who it applies to.

All of this stays quite simple in field with little complexity like mechanics. If we can easily be confused by it, it is far from a really complex field like the psyche... It is indeed something else! During Balint are reported encounters between therapists and patients, meaning two psychic devices that dialogue to go forward through the paradoxes and hardship of life and thoughts.

We have to be really humble in front of this unfathomable complexity, far away from mechanics! In Balint, it will be twice filtered: on one side, the story we tell of ourselves is a part of our being that can be translated into words. It is then only a very small part! On the other side, the story the therapist tells to the group is also filtered by them, that only renders a really tiny part. To this double reduction is added what the group's members can grasp from it, which makes it a third reduction.

It is truly because of those drastic reductions that Lacan could say of his supervised young students that they were doing anything but... that they were also always right!

It is just simply that they were directly in contact with their patient's hyper-complexity unlike their supervisor, would he be called Lacan, Freud or anybody!

Is it why the practice of the supervision of an analyst by another one is so widespread and yet little controlled? It circulates in the analytic field that the patient is a bit sacrificed to the good functioning of the supervision...

I think that this can in fact happen when advice are given in this setting! When this happen, the direction the psychotherapy takes escapes from both protagonists living it to get in the supervisor's hands who lacks what represents the heart of every psychotherapy: the complex encounter between two psyches.

To get back more directly to our subject, this is exactly what happen when a guiding advice is thrown in a Balint group. The more the person giving the advice is invested, as the leader of an analytic school or as a reference of knowledge, the more risk there is for a massive deleterious effect by the reduction we described and that isn't accounted for at all anymore.

Thus in this Balint session, a participant reacts to the story of another describing a situation where the patient is taken care of by a psychologist and a psychiatrist. Paradoxes created by this situation fed by the difference of speeches that the patient gives to one another is putting off the psychologist participating in the Balint group. Advice is giving by the other participant to call the psychiatrist to even out this complex situation. Thankfully, the group worked on this remark,

finally showing that this advice would have broken the fragile balance the patient controlled by those "manipulations" that were also careful progress on both sides at their rhythm...

Conclusion

Thus, a Balint group that allows the emotional weight of our work as therapists to be collectively shared can be of great help, however under certain conditions.

The first is to see that what protects, supports, allows a development, that is to say the group when it is welcoming and kind doesn't protect from a certain weight, from the risk that all group consensus can weight on each person's individual creativity. It always exists between the two a certain form of paradox that might be better to accept than try to shrink.

The second is that the feeling of mistake, the weight of a certain guilt from the therapist confronted to the numerous difficulties of a psychotherapy can thanks to the Balint group change into a new knowledge, a fertile development.

In the third, the leader's art and that of the group itself is to maintain a development thanks to and despite the amount of questions about the case in the group. Here again, remembering that all those clues can deepen as much as they can blur the way make accepting this paradox possible, even inevitable.

Finally, the use of advice being often the exact opposite of a psychotherapy's goal which is that the patient find their way again and the enjoy to look for it, it seems useful to finish with this point.

Maybe then, without all those aspects being exhaustive, all of this allows for an enjoyable progression of a Balint group and participate to help the therapist in a comfortable practice, which is anyway the first ambition of the Balint practice.

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Psychosomatic Medicine and Balint Group Work - Integration of Basic Principles and Practical Interaction

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Abstract

The article describes integrative relationships between the basic approaches and ideas of psychosomatic medicine and Balint supervision in physicians and other health carers. The article analyses the history of their creation and common principles very much related to both complex issues of doctor-patient interaction and psychosomatic disorders tending to be positively affected by the Balint group work of health carers.

Keywords: psychosomatic medicine, physicians, Balint groups, integration, positive effectiveness.

Psychosomatic Medicine and Balint Group Work - Integration of Basic Principles and Practical Interaction

In December 1970 Michael Balint had an interview with Phillip Hopkins, his close associate, colleague, friend and long-time editor of *Journal of the Balint Society* (UK). When telling about the history of the development of Balint groups and their connection to clinical medicine especially to general practice, Balint noted that his deep engagement and even passion for psychoanalysis, which later formed the grounds and practical basis of the Balint supervision technology, was more than a turning point in his life. It got him reflecting over the ways of development of various psychosomatic disorders and the productivity of psychoanalysis in their diagnosis, treatment and in-depth understanding of various complicated aspects of doctor-patient interactions and relationships. He realized that functioning of the human body is closely linked to one's psychological features and states, one being integral part of another and both affecting each other, while manifesting themselves in a psychosomatic unity as well as in professional communication. For this reason, Balint can be rightly considered as one of the pioneers of modern fundamental psychosomatic concepts.

Analyzing historical roots of Balint groups work, one may note that today, when clinical practice commands increasingly expensive, potent and, accordingly, unsafe medications, the issue of an emphatic and humane medicine is becoming the central. Michael Balint seemed to have foreseen the situation, offering one of the most successful solutions to the task long before the 'evidence-based medicine' began forming into a new scientific discipline and even to a new clinical philosophy. At the same time he stressed that what we now call 'phenomenological' approach, is despite difficulties in understanding and interpretation, an absolute condition in preserving humanistic foundations of medicine in general, specifically in the area of mental health.

The analysis of over half a century's Balint work in various countries showed that Balint offered a very effective method to help physicians of different specializations and other health carers decrease their emotional strain in working with 'difficult' patients, often including those with psychosomatic and somatoform (mental in reality) disorders. This promoted the doctors' adoption of 'interpersonal' psychology in their work, while trying to study the nature of their relationship with every patient and the factors complicating the relationship, also shedding light on the concomitant drop in the effectiveness of the proper medical work. Over time, this method helped physicians to gradually shift their focus from the *illness-centered* approach to the *patient-centered* one. The results were reflected in the proceedings of the first International Balint Congresses, held under characteristic mottos – "Patient-Centered Medicine" (London, 1972) and "The Human Face of Medicine" (London, 1978).

In the medical profession there are varying degrees of deficiency in regards to professional communication with colleagues when it's necessary to become clearer about the patient. This significantly increases the probability for the doctor to distort the internal image of his/her professional activity and self-identification, resulting in decreased ability for self-criticism and self-reflection, and increase of professional rigidity. For many years now, the international experience of doctors' education and training places an emphasis on the relevance of studying and, subsequently, supervising various aspects of practical communication with patients, the latter considered one of the most important and significant indicators of the doctors' experience and professionalism. According to both doctors and patients, communicative competency is believed to be among professional qualities essential for the effective performance of the formers' professional activity. These skills do not simply increase along work experience, rather, they need to be constantly developed and improved in the process of peer supervision.

One of the prerequisites for creation and sustainability of such an effective form of analytical supervision as Balint groups is an analysis of the latter's professional health indicating a rather major need for collegial feedback in ambiguous and complicated clinical situations, very frequent even in case of significant and long work experience. Ironically, often the pronouncedness of that need depends on the professional experience, especially related to the psychosomatically oriented health care, – the more experienced and skilled doctors show greater interest in the exchange of their experiences and constructive discussions, as well as attention and support from their colleagues than the young ones.

There are also other important characteristics of the doctors' work, full of challenges, related to inevitable psychosomatic and psychosocial nature of human diseases, that determines the necessity of a Balint supervision: the specifics of the work and care we provide, are largely determined by the proper professionals' personal features rather than those of a patient, there is evident emotional saturation of interpersonal interaction with the patient in the process of treatment and care delivery. And of course, there is an inevitable 'demand' for constant creative self-development, self-awareness and self-reflection that subsequently leads to a better understanding of the patient and to a higher level of care.

There is a very close integration between basic ideas of psychosomatic medicine and Balint groups work grounds, determined by a common idea of attention to very complicated and sophisticated psychological aspects of interaction with patients. In this context, Balint wrote, that a doctor has to discover his own ability to spy out certain things concerning his patients that are hardly possible to express in words, and must consequently begin by 'eavesdropping' on the same sort of language within himself (*translated from the available Russian version*).

One of the founders and very bright leaders of the International Balint movement, professor Boris Luban-Plozza (1923-2002), the author of the world-known Ascona Model of conducting Balint groups, was also renowned for his fundamental studies and books in psychosomatic medicine. His book 'Psychosomatic Disorders in General Practice' (1992) was repeatedly published in all major European languages (his Russian-language books were reissued several times). Luban-Plozza's concept, suggesting that the in-depth psychological understanding of the patient's emotional problems has to be a part of a doctor's arsenal on the same scale with medicines or medical equipment, successfully unifies a psychosomatic approach to the holistic perception of the patient with Balint groups, aiming to understand the complexities of such 'difficult' patients' communication with their doctors.

The very same viewpoint was earlier expressed by E.Weiss and O. English (1943) who noted that psychosomatics is a medical approach which doesn't diminish the meaning of the physical state of the patient, at the same time giving significantly more attention to the psychological one. Also, V.Weizsaecker (1949) wrote that any medicine should be deeply psychological otherwise it won't be medicine at all. This also helps to actively approximate the ideas of integrative (that is to say psychosomatic) medicine and the Balint work philosophy, as in both cases we face the world of a multitude of open questions about the so frequently complicated character of the doctor-patient communication and hidden answers to those questions.

The formula suggested in Balint's book "The Doctor, his Patient and the Illness" (1957), which links the doctors' psychosomatic competency with the effectiveness of their supervision in Balint groups, turned out to be so productive that it still continues to inspire many researchers and practitioners to develop it in various aspects of their activity. Balint wrote that the most powerful therapeutic tool the doctor possesses is himself. It's not so much the medicines the doctor prescribes to the patient, as the psychological environment and communication they

were prescribed in. That means that as in case with other medicine one should carefully weigh the indications for prescribing such 'drug' as the doctor as well as the dosage, restrictions, best ways of administration and even possible side-effects or complications.

Another good example of such integration of the studies of psychosomatic disorders in medical and psychotherapeutical practice (especially communicative aspects of therapy) and Balint approaches can be found in professor Peter Shoenberg's book "Psychosomatic: The Uses of Psychotherapy" (2007), which gained wide recognition within the International Balint Federation. Peter Shoenberg is not only a consultant psychiatrist and psychotherapist but also is one of the leading specialists in Balint supervision, it's technology and effectiveness assessment. In this book the author demonstrates how attention to various aspects of the doctor-patient communication and their in-depth analysis leads to increasingly successful therapeutical practice through better understanding of the role of psychological factors in the development of psychosomatic disorders as well as through improved satisfaction of both participants from their mutual interaction and better patient's compliance towards the treatment.

The timely and correct diagnosis of psychosomatic disorders in the general practice becomes crucial in offering successful medical assistance, the most important element of it being the quality of doctor-patient communication as the major focus of the analytical work in Balint groups.

There are close practical links and sometimes even organizational integration of medical and Balint societies in many countries world-wide, where national Balint societies are actively connected and cooperating with national psychosomatic ones, associations of GPs or associations of psychiatrists or psychotherapists. As a good example of such integration we can note that since 1987 Germany has been practicing the 'basic' psychosomatic training for all doctors, with the state program stipulating for a minimum of 15 obligatory Balint groups' sessions. In Russia, especially in St. Petersburg reports and discussions about various aspects of Balint supervision and its effectiveness in the doctors' professional development and training are regularly included in the programs of different medical congresses, conferences and workshops as well as in the programs of postgraduate training curriculums, especially those related to psychosomatic issues of medical practice.

Balint groups provide heir participants – doctors and other health carers with an environment for deeper and more conscious analysis of their work and its communicational aspects, development of self- reflection, better understanding of the patients and themselves in the process of complex interaction, which can be classified as one of the key problems of psychosomatic medicine. One of the solutions is in the achievement of the active cultivation of empathy in the process of Balint supervision. It's effectiveness is conditioned by gaining the new and more constructive experience of the unknown and uncertain which exists in the work of every doctor and in every case of their communication with 'difficult' patients. So the group helps to increase professional self-esteem and the level of satisfaction with their work. Balint groups are a great way to eliminate professional 'loneliness' of doctors , help them adopt more

positive strategies of thinking and achieve new levels of competency, first of all, communicative competency, allowing them to develop higher resistance to various frustrating aspects of their work, often observed in the treatment of psychosomatic disorders, currently viewed as the 'diseases of human civilization', and thus becoming more and more common in the medical practice.

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Cap. 10
Workshops

The Art of Medicine: A Workshop to Help us See Through Other Eyes

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Description of Workshop

The Art of Medicine is an innovative collaboration between an academic healthcare system and a regional modern art museum. It is the first program to combine Balint with an art analysis technique called Visual Thinking Strategies (VTS). Physicians and Advanced Care Practitioners (ACPs) who work within the academic healthcare system are invited to participate in a series of 6 evening sessions at the museum, each of which lasts an hour and a half. Sessions begin with the exploration and group discussion of incredible works of art, led by trained VTS facilitators of the museum. Museum staff use VTS to facilitate the identification and examination of various perspectives and emotions that can be found in various artworks. The VTS session is followed by a moment of reflection about the participant's own emotional reactions to the art. After this moment of reflection, faculty from the healthcare organization then lead participants in a Balint group. The case presented typically bears heavily on the artwork that was explored during the session. Functionally, the ambiguous nature of modern art appears to accelerate the Balint process by priming participants to seek alternative perspectives and engage in deeper emotional processing.

The workshop will include a background and description of the Art of Medicine program, including a brief history of medical humanities, the use of VTS in medicine and medical education, and the development of the Art of Medicine program (15 minutes). Participants will then experience an Art of Medicine session, inclusive of the Balint session (60 minutes). The regional art museum will provide the artwork, or high-quality replicas of the artwork, for the Art of Medicine workshop, and a representative of the museum will lead participants through a VTS session. Participants of the workshop will then engage in a Balint session. Subsequently, workshop leaders will facilitate discussion and feedback on the delivery and content of the program, to further refine and improve this experience (10 minutes). Finally, we will provide a comprehensive and practical guide to integrating VTS in participant's home Balint groups, using existing resources (5 minutes). Total = 90 minutes

Group Therapy, Group Supervision, Balint Group: Similarities and Differences

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Today, **group psychotherapy** doesn't have a single definition, since it has been given many changing definitions throughout the direction and almost an age-long-history of the groups. At present, group therapy is defined as a form of psychotherapy where the participants of the specially created group regularly meet, under the guidance of a psychotherapist, to achieve the following goals: to solve internal conflicts, remove tension, correct behavioral disorders and other psychotherapeutic work. There are methods in psychotherapy which were initially developed for group work, such as: psychodrama, sociodrama. First person to use the term 'group psychotherapy' was J. Moreno, the founder of psychodrama – essentially, a group therapy – which he introduced in the U.S. in 1925. Group therapy blossomed in the 1960s, when the method was used for different clinical conditions and different types of clinical problems; C. Rogers attached major importance to forms of group therapy in the framework of humanistic psychology⁶.

In one form or another, group therapy proved effective for a wide range of mental and emotional disorders and life situations. It's often used simultaneously with individual therapy and is especially beneficial to people with communication problems. Group therapy works especially well for people with interpersonal problems who need to realize how their problems affect other people.

Initially, group therapy was prompted by economic reasons. Later on, different assessments were given to the group input, group dynamics and mutual impacts of group members and the psychotherapist. You could say that today supervision is following in the footsteps of group therapy – from cost-effective groups to the understanding of the positive effect of group dynamics.

Supervision is a method of theoretical and practical improvement of qualification for specialists in the areas of psychotherapy, clinical psychology, etc. in the form of professional

consulting and analysis of the quality and viability of the practical approaches and psychotherapy methods used. Supervision reflects the "technological aspect" of psychotherapy. Psychotherapy allows the patient to express his emotions at a therapy session, supervision allows the (supervised) psychotherapist to present selected samples from his psychotherapy sessions⁵.

In many cases, the limits of effectiveness in the psychotherapy are determined not by the specifics of the clinical case or the patient, but rather by the "limits" of the psychotherapist himself².

Supervision is, first and foremost, a professional psychological interaction where the therapist can describe and analyze his work in a confidential environment. Its main purpose is to help him meet the client's needs in the best way possible. Participation in the supervision allows the consulting psychologist to share his emotions, to identify and mark the difficulties in working with the client, get feedback, analyze reasons behind his difficulties, outline the strategy and future work with the client. Thus, during the supervision, the expert develops and hones his professional skills, with a specific case as a focus of the supervision.

Psychotherapy is a system of a psychological influence on a person's psyche, and through it, on the whole body, used to treat and prevent disorders and states of disadaptation, boost health or other purposes (V. V. Makarov, 2006). Psychotherapy not only solves problems related to the malfunctions of the human body but also those caused by various difficult situations – interpersonal relations, professional issues, existential problems, so-called "personal growth" problems. **Supervision and psychotherapy are, in essence, parallel categories linked into a single system.** This connection is provided through a psychodynamic space created during a supervision session and forming of a positive transference, with unconscious identification and imitation as a part of it. Even though supervision may have a therapeutic effect, and supervisor be a great psychotherapist, supervision is not psychotherapy. Using supervision as a type of psychotherapy makes the supervisor a psychotherapist and the psychotherapist his client. Mixing these two functions causes a problem of ambivalent relationships that can seriously negate the value of the process of supervision. With the dominant psychotherapeutic component, the situation can activate defense mechanisms of the supervised expert [8].

According to D. A. Fedoryaka the tasks of the supervision can be divided into two groups.

Clinical-psychotherapeutical (organizational) tasks:

- Help in organizing the process of treatment
- Correction of psychotherapeutical contract
- Determining the consistency of work performed, psychotherapy targets and forming of an individual psychotherapeutical program

Psychotherapeutical (essential) tasks:

- Conceptualization of the process and essence of the psychotherapy during the session. This should result in forming a comprehensive understanding of the essence of the problem, specifics of the patient and his issues, the type of therapy employed by the supervised expert
- Prophylactic of emotional burnout through support and shared responsibility for the psychotherapeutical case. This should result in the change of the emotional background in the supervised expert upon completion of the supervision session (often from anxious to joyful)
- Training the supervised expert to perform specific psychotherapeutic tasks using an example of the presented case. As a result, the supervised expert develops a skill and uses it in his work with a client.

Fedoryaka believes supervision is a broader notion (as compared to Balint groups), helping to solve not only essential but also organizational, methodical and training tasks. This context is necessary for young psychotherapists as well as in building a professional help system in clinics and institutions. Balint groups are a more specialized type of supervision suitable for active practitioners and aimed at essential aspects of the psychotherapist's practice.

It may also be noted that supervision is closely related to Balint groups in the field of psychotherapeutical (essential) tasks with the exclusion of acquisition of specific skills by the supervised experts, using case presentations as an example. As for organizational-clinical tasks, they remain fully integrated into the process of supervision. Thus, both options have a number of intersecting points, allowing to solve the tasks on hand and boost psychotherapeutic assistance through improving the practice of experienced specialists, on one hand and through training of young specialists on the other [7].

I believe it would be appropriate to drop the word supervision with reference to Balint groups, since in countries with the newly developing Balint movement it's important to differentiate Balint groups from other forms of group work in order to make the specifics of Balint groups clear. On the other hand, how can we promote Balint groups, if colleagues say they already visit supervision sessions, and Balint groups could be viewed as a waste of time and money.

What else is common for all three types of groups?

At the beginning of work, all types of the abovementioned groups are recommended to interview every group member, thus performing a mini diagnostics (since all these groups must be safe places for their participants) to determine whether a person could benefit from group work, or politely refuse him if his participation could harm others.

The second stage – concluding a contract (verbal or written), is first of all an issue of limits, both for the group leader and its participants. Both the leader and the participants must be informed about the time and venue of the group work. This type of work may actualize lots of anxiety in the group members and the stability in time and the venue may help the participant stabilize himself. Also, in this manner we're urging to respect the limits of both the group leader and the participants as the group work is only possible where there are several participants.

The role of the leader in all types of groups.

I believe the role of the leader in group therapy to be more of a facilitator. The leader's role should be more obvious during the supervision, the leader of the group being the one to summarize all that's been said by the participants. There are different forms of group leadership in Balint groups. Some prefer the role of a leader, others that of a facilitator. But I believe, in any case, the members of the group, and most importantly, the case presenter and the supervised expert must realize and feel that the group leader acts as a guarantor of the safe place and assumes responsibility for everything that happens in the group, rather than acting as a bystander.

If the group therapy and Balint group attendance are mostly voluntary, supervision is often mandatory and many modalities include specific number of supervision sessions.

If at supervisions, the prescribed number of sessions is 4 for each client/patient (in particular, for young specialists, although, I believe, the importance of supervision doesn't lessen with the experience), at Balint groups, some participants may never have their cases analyzed, while others can present several cases.

If the rules of Balint group forbid giving advice, advising is essential during supervisions, so it may be said that the supervised expert not only aims to understand the case, but also get advice from the group participants and the leader on his further steps, tactics and strategy and hear their opinions about his choice of tactics and strategy and specific methods of diagnostics and therapy they could recommend.

Factually, at the end of the supervision, summarizing all that's been said by the participants, the supervisor suggests the final algorithm of diagnostics and therapy, of course, also explaining his reasoning behind specific recommendations.

Collegial support as well as criticism- and non-evaluative acceptance is necessary in all three types of group work. However, in group therapy, there is room for critical statements; the format of the work allows it, since this is a place where aggression and other negative emotions can be worked on. Criticism and evaluation are possible at supervision, since otherwise it will be impossible to analyze the case or the expert's work; still the criticism should be well-chosen. The rules of Balint groups disallow the use of criticism and evaluation, the focus being on the doctor-patient, psychologist-client relationships.

Frustration. Of course, it's clear that there's no progress without frustration. However, according to Professor Vinokur, there should be a limited amount of frustration in Balint groups, while the case presenter must be surrounded with support to be able to bear the frustration. I believe, this rule can also be used during supervision and group therapy.

In Balint groups, we don't use psychological and medical terms, while we can't do without them at supervisions.

In Balint groups, the main object is emotions, feelings, bodily sensations. It's natural that we cannot switch our emotions on and off at our own will during supervision (some supervisors even ask the participants to share their emotions caused by the supervised specialist's case during the first circle). However, here it's important to decide on a specific diagnosis and treatment to recommend to the client/patient, and for that we also need to be rational.

As the president of I.M. Sechenov First Moscow State Medical University, Petr Glybochko told in an interview with Rossiyskaya Gazeta daily, today, when doctors are assisted by high-tech diagnostic facilities, there should be no medicine without emotions, the doctor mustn't turn into a "computer in a white robe" [3]. We can use the same analogy for the work of psychotherapists, psychologists and other specialists of helping professions.

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GROUP THERAPY THERAPY	BALINT GROUP	GROUP SUPERVISION
Form of psychotherapy where the participants of a specially created group regularly meet, under the guidance of a psychotherapist, to achieve the following goals: to solve internal conflicts, remove tension, correct behavioral disorders and other psychotherapeutic work. There are methods in psychotherapy which were initially developed for group work, such as: psychodrama, sociodrama.	Method of group training work aimed at improvement of professional communication skills, decrease of professional stress and "emotional burnout" in doctors (specialists of helping professions).	Method of training and improvement of qualification in the field of psychotherapy where a more experienced, specially trained psychotherapist provides counseling to his colleague; it allows the supervised psychotherapist to consistently see, realize, understand and analyze his professional actions and behavior.
GENERAL		
<ol style="list-style-type: none"> 1. Preliminary interview with each group member 2. Concluding a contract (verbal or written) 3. Respecting the limits (of the method, leader, referent/supervisor, group members, time limits for holding the group session) 4. Collegial support 5. Frustrations 6. Confidentiality (not discussing the case outside the group, not giving the actual name of the client, patient) 		

DIFFERENCES		
Tasks, goals:		
The majority of types of group therapy aim to help group members solve their individual problems	Encourages doctors to appreciate their skills for interpersonal relations and their limits, improves perception and understanding of the doctor-patient communication, allows doctors to see their "blind spots" in their communication with patients	Focuses on the psychotherapeutical process and aims to develop knowledge and skills, promoting improvement of the psychotherapist's professional activity
Leader's role		
Facilitator	Leader and facilitator	Leader
Use of psychological medical terms		
Not encouraged	Not allowed	Allowed
Focus of attention		
	Doctor-patient, psychotherapist-client, etc. relationships	The analysis is performed at one of several levels: patient, psychotherapy, psychotherapist
Advice		
Possible	Not encouraged	Necessary
Criticism		
Possible	Not encouraged	Constructive criticism is used
Evaluation		
Possible	Not encouraged	Used

The doctor and his patient, when the patient is a doctor

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The aim of the workshop is to raise the awareness of how we as doctors take care for ourselves and address our own health and fragilities in professional life. The question is, if this is a case for a Balint group, and how you will deal with it.

The workshop is initiated by a 10 minutes discussion with a neighbour about recent experiences as a doctor for a doctor, a doctor for the family or as a doctor-patient. The workshop leaders present a few personally experienced dilemmas.

In a fishbowl, a Balint group, discusses a personal case.

Finally some of the most interesting issues and dilemmas will be summarised in plenum.

Explore the Mysteries and Magic of the Developing Co-Leader Relationship

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Overview

This ninety-minute workshop is designed for anyone who is interested in the experience of co-leadership. It is suitable for both those who have worked with a co-leader and those considering doing so.

We will creatively explore the challenges (and the magic!) of being in a co-leader relationship. We will examine the preparations and the dynamics of the developing co-leader pair. There will be reference to co-leadership preparations for the leadership of Balint groups that meet a number of times within a short timeframe, such as a Balint workshop or Balint leadership training workshop.

1. Learning objectives

By the end of the workshop participants will:

- a. Have reflected on their experiences in the development of their co-leader relationships
- b. Have clarified regional and cultural differences, and those related to various professional backgrounds, in the development of co-leader relationships
- c. Have considered how synergistic a co-leadership relationship needs to be for successful co-leadership
- d. Have considered the development of co-leader relationships in relation to preparation for Balint intensive workshops and Balint leadership workshops as well as for ongoing Balint groups.
- e. Have shared ideas and resources to assist with the development of effective co-leader relationships

2. Session outline

- a. Briefly introduce ourselves and our backgrounds, then invite people to say their name and country from which they come. (10 MINUTES)
- b. Clarify the learning objectives and talk about our thinking that led to the development of this workshop (5 MINUTES)
- c. Laurie gives her perspectives on the co-leader relationship as a psychoanalytic psychotherapist (5 MINUTES)
- d. Frank gives his perspectives on the co-leader relationship as a general practitioner/family physician (5 MINUTES)
- e. Joy gives her perspectives on the co-leader relationship as an organisational consultant (5 MINUTES)
- f. Participants are invited, in groups of five, to: (30 MINUTES)
 - i. Reflect on their experiences in the development of their co-leader relationships
 - ii. Clarify regional and cultural differences, and those related to various

professional backgrounds, in the development of co- leader relationships

- iii. Consider how synergistic co-leader relationships need to be for successful co-leadership
 - iv. Have considered the development of co-leader relationships in relation to preparation for Balint intensive workshops and Balint leadership workshops, as well as ongoing groups
 - v. Have shared ideas and resources to assist with the development of effective co-leader relationships
- g. Each group to give a 5 minute summary of their thoughts followed by large group discussion (25 MINUTES)
- h. Thank you and closure of the workshop (5 MINUTES)

Balint Group Co-Leadership - Opening a Window to the Group Work - Action Research

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The traditional co leadership that started with the Balint couple, Enide and Michael, was adopted worldwide in Balint groups.

You are invited to join us at a workshop exploring the relations of Balint group co leaders and the way it influences their group.

We have been co leading our group for five years and we are aware that the nature of our relationship, often affects the group work and its dynamics. In our pre and post group discussions with each other, we constantly look at our work together and ask ourselves if it helped or disrupted the group process.

We are going to ask ourselves if and how co leadership opens windows to help with the primary task of understanding the complexity of doctor-patient relations. We intend to look together into parallel processes at three different levels: co leaders, presenter-group and doctor-patient. We will ask ourselves how co leadership furthers the understanding of subtle and hidden themes in the relationship in the clinic through the prism of the work of the group

The diversity of and variations in co leaders (gender, age, profession, experience, culture, and more) allow the different voices within the group to be expressed and heard and helps make us aware of the diversity and variations in the doctor and patient other than their different roles in the clinical meeting.

We trust that the doctor presenting his dilemma to the group is an experienced physician who invites the group to help him understand and resolve his dilemma. Something that happens in the room with the patient does not allow the air to flow and prevents him in helping the patient to feel better.

Some of the reasons for experiencing an impasse and/or lack of air in the clinical work with the patient are conscious, some of them are more covert. The presenter enters the group with an expectation that the work of the group will help remove the impasse and let the air flow freely.

The aim of the workshop is to explore with the participants how the presence of two leaders enhances the process of solving the dilemma and allowing the air to flow.

Workshop Program

- 10 minutes: A short introduction - aims and goals.
- 20 minutes: Collecting evidence from participants [from the questionnaire] - how did the work with two leaders (either as participants in a Balint group or as leaders) influenced the Balint primary task.
- 50 minutes: A Balint style discussion on the narrative told in the first stage.
- 10 minutes: closure.
- The participants are asked to register in advance and complete a questionnaire.

Cap. 11
Posters

“Balint-Like” Groups for Medical Students During Their 3 Years of Clinical Rotations - A Description of a New Project

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In 2016 a new course opened at the Technion Medical School called “The Capsule”. The course aims to strengthen professional identity among medical students by allowing them discrete sessions to share their experience from the clinical rotations, to discuss and reflect on ethical dilemmas, to give and receive feedback from their peers, to practice attentive listening and expression of empathy. It is run in small groups and led by experienced staff physicians who serve as facilitators to the groups during the 3 clinical years.

I (AR) serve as the facilitator for one of these students groups. Being an experienced Balint group leader, I led the sessions in a Balint format, with some adjustments due to the nature of the group and the guidelines given by the course coordinators.

My group was comprised of 10 students. A myriad of themes was presented during these sessions: The establishing of student-patients relationship, the role of the student in the medical team, ethical dilemmas related to patient care, proper and improper conduct of doctors, treating family members and friends, and issues related to the students’ professional future as becoming a doctor, choosing a specialty, and preventing burnout. All students got engaged in the sessions, and stated that they were very important and helpful for them.

We believe that early exposure to Balint groups in medical school may enhance the sensitivity of physicians to the emotional and relational aspects of their work.

Empathy in a Multicultural World: A Challenge for Balint Groups?

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Empathy involves an understanding of experiences and concerns regarding another person. Empathy can lead to positive patient outcomes including greater patient satisfaction and compliance. However, in multicultural societies, establishing a doctor-patient relationship of empathy poses distinct challenges.

The aims of this work are: to present a summary of the main difficulties in the doctor-patient relationship in the context of different cultures and to discuss clinical resources for enhancing ethnocultural empathy.

A search was conducted in the Pubmed database with the Mesh terms: medical and empathy and cultures. Articles published in the last 10 years were selected, obtaining a total of 230 articles, from which those focused on improving empathy were selected.

Cultural meanings of symptoms are highlighted through the difficulties experienced in a multicultural relationship. The Balint groups are a resource for the physician to find "new" ways of communication and so doctors can use them to improve ethnocultural empathy.

Themes of Intrapphysician Existencial Conflict in Four Years of Physician Balint Groups in a Rural American Residency Program: Moving Toward a Phenomenologic Tool to Address Early Physician Stress

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Abstract

A rural based resident physician training program with a long established Balint program utilized a prospective descriptive correlative mixed methods research project focused on analyzing the annual (Balint is organized around new physician cohorts starting residency) themes that emerge and when they emerge in the group process over four years with quantitative assessment of physician burn out and stress indicators and qualitative assessment of thematic elements of Balint case presentations. Themes range from the difficult patient, the unmotivated patient, the concerning patient, and the patient that provokes. These various themes represent

different stresses the physicians identify, and correlate to a continuum of types physician stress and existential questions which arise in the early development of physician and suggest that using Balint as a tool of phenomenologic experiencing can reduce early distress and improve coping with both patient and profession stressors.

Balint Groups in Medical Graduation: An Experience Report

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Introduction

The Balint groups have been part of residency education for decades, with a lot of academic production. Yet, during the medical graduation, the academic production about group Balint, is scarce.

Objective

Describe the implantation of Balint groups in the medical course of University of City of São Paulo (UNICID).

Description of the experience: Approximately 1 year ago, we began the implantation of Balint groups with students of the fifth and sixth year of the medical course. In this period, they have an immersion of the field of practice. Groups of 12 to 15 students are formed, with meetings every 3 weeks. This participation is mandatory and at the beginning of the first group, we explained about the method.

Conclusion

The Balint groups during medical graduation is a big challenge. However, the educational value of these groups for medical students in building communication and empathic skills, is invaluable.

"The Difficult Patient" - The Perspective of the Physician in a Balint Group Context

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Introduction

The doctor-patient consultation is an encounter between two individuals with their contents and implicit meanings and negative emotions. The physical and mental condition of the physician, his skills or attitudes can precipitate a difficult consultation. The analysis of disruptive behaviors either by the physician or the patient and associated emotions, in the Balint Group (GB), allows us to understand how they affect the doctor-patient relationship.

Material and Methods

This work proceeded to the descriptive analysis of these emotions and the circumstances in which they were generated, from the report of cases presented in six GB in Portugal. Results: 66% of the users are male, 88% of low socioeconomic condition, 77% of the consultations have a 3rd person present. The "case" doctors are 41% female, 77% female. Negative emotions are, in more, primary such as irritation, indignation, embarrassment and anxiety. End-of-life cases and resource management in health are the main difficult circumstances for consultation.

Conclusion

There are difficulties for physicians to meet the "intended" physician, the disease "offered" by the patient as well as to assume their role as social regulator.

Is Balint Training Associated With the Higher Degree of Empathy Among Primary Health Care Doctors?

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Keywords: Doctor-patient relationship, Balint groups, primary health care, empathy, IRI.

Summary

The aim of our study was to examine whether the participation in Balint group is associated with a higher degree of empathy amongst primary health care doctors.

Methods

This investigation was conducted on a population of 210 doctors employed in primary health

centers in Belgrade. Of 210 doctors, 70 have completed Balint training, whereas 140 doctors have never attended it (Non-Balint group).

Results

Doctors who completed Balint education had significantly higher scores on subscales Perspective Taking, Fantasy and Empathic Concern compared to doctors who did not complete it, $p < 0.001$. Regarding the sub-scale Personal Distress, there was no statistically significant difference between doctors of these two groups, $p = 0.530$. In the multivariate logistic regression model for the sub-scales Perspective Taking and Empathic Concern, the only significant predictor was the Balint group, and for the Fantasy sub-scale, Balint group and doctors specialists were identified as a significant predictor.

Conclusion

According to our results, Balint groups are associated with the higher degree of empathy.

Bringing Balint Groups to Undergraduate Medical Education Poster

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Emotions are increasingly recognised as playing a central role in the professional development of doctors, and yet they are not given explicit attention in most undergraduate medical curricula¹. Knowing how to teach medical students about the role of emotions in medicine can be a challenge to educators². The aims of this study were to provide an aspect of training that is not addressed elsewhere, and that participating in a Balint group is an important part of training as a doctor. In conclusion, Balint groups provide an effective means of educating students about role of emotions in the doctor-patient relationship and are valued by students as an important element of medical training that is missing from the curriculum.

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Balint Groups Implementation in Greece

The First Reported Experiences

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Introduction

The implementation of Balint Groups has different challenges in each country, influenced by cultural, organizational, political factors and lack of assemblage of "psychotherapy" title criteria at European level»

Aims

- To obtain information regarding the perception of difficulties from Physicians and Psychologists in daily work with patients in Greece.
- Educational needs in order to introduce the Balint Group Method into the healthcare structure.

Method

For the qualitative study we used qualitative research methodology including surveys, participant observation and semi structured interviews.

Two heterogeneous groups were organized. The interviews and the questionnaires were analysed with a systematic text-condensation method. The difficulties were described by the

Balint Group Leaders and the participants.

Results

Balint Group Leader challenges: Integration in group of participants with different knowledge and cultural background.

Participants challenges: Competition, personal antipathies, financial difficulties.

Conclusions

The Country requires demand flexibility and additional offer of theoretical knowledge as useful contribution to facilitating understanding and managing difficult cases.

<https://www.hellenicbalintsociety.gr/en>

EXPERIENCE OF A VIRTUAL BALINT GROUP IN BRAZIL

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Introduction

In Brazil, since 2014, we have called "WebBalint" the Balint Groups conducted through videoconference, using the Zoom platform.

Objective

Report reflections about the process lived by participants of a Brazilian virtual Balint group.

Method

Collective analysis of the reflections found in 4 narratives made by the participants of a virtual Balint group, seeking to construct a discourse of the collective subject.

Results

Despite the initial strangeness of having a screen connecting people and stories, bonding was satisfactory. It was reported that, even with the geographic distance, the setting privacy and freedom from distraction was guaranteed as in a regular Balint group. The participants reported a change in the way they saw their case.

Conclusions

The virtual Balint group can be a transforming experience, providing participants with insights, mobilizing emotions and creating positive changes in clinical practice. These perceptions and changes will be better deepened in a qualitative study.

Farewell

"A saudade é o que faz as coisas pararem no Tempo".

"Se me esqueceres, só uma coisa, esquece-me bem devagarinho".

"Saudade is what makes things stop in the Time"

"If you forget me, just one thing, forget me very slowly"

Mário Quintana

Brazilien poet, 1906-1994

