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'Zeroes & Heroes': The Experience of Balint Leaders during COVID-19 Pandemic Lockdown

Balint Society Essay Prize 2020 joint winner

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Introduction[1]

As Michael Balint was developing his group for the benefit of general practitioners;[2] it almost certainly did not occur to him, or his wife and collaborator Enid, that there would ever be a time when neither the group members nor the leaders were in the same room! Neither did it occur to us, as relatively new leaders of Balint group, before COVID-19.

Four sessions into the new Balint group with junior psychiatry trainees, we felt forced to set aside our initial dismissal of virtual Balint as lockdown took place. We were tense, had never done this before, but we gave it a go.

There was psychotherapeutic literature that explored remote therapy and virtual Balint groups, for which we were thankful.[3] Nevertheless, we sensed that we were stepping into new, undiscovered land, and we kept a joint record of our group's journey, which continued remotely until the easing of lockdown in the summer. Our desire to write about our experience arises from the shared reflection we had throughout this process.

In this essay, we explore the importance of maintaining our Balint structure, which has been adapted locally to suit the psychiatry trainees' needs, and how through this, the group was able to explore the doctor-patient relationship in light of a pandemic. We also reflect on apparent links between the external reality of the pandemic and recurrent themes in the doctor-patient relationship, as well as its

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[2] Balint M. (1954). Training general practitioners in psychotherapy. *British Medical Journal*, 1:115–20.

[3] Lemma A. (2017). *The digital age on the couch: Psychoanalytic practice and new media*. London: Routledge; Nease Jr DE, Lichtenstein A, Pinho-Costa L, Hoedebecke K. (2018). Balint 2.0: A Virtual Balint group for doctors around the world. *The International Journal of Psychiatry in Medicine*, 53(3): 115-25.

possible effect upon the group. Towards the end, we could not resist reflecting on the gifts (welcome and unwelcome) that technology brought our Balint group in a time when we question if this particular breakdown may lead to any breakthroughs.

Why Was It Important to Maintain the Original Structure of Balint Group Despite Pressures to Hold an Informal Peer Support Group?

While a Balint group is a supportive structure for doctors and its effects can be therapeutic, it is not designed to be a 'peer support group' and indeed not a 'group therapy'.[4] Instead, it insists on making the doctor-patient dyad the centre focus.[5] The burden that medical staff (all health staff but doctors in relation to our discussion) are being subjected to as a result of the COVID-19 crisis may have imposed an apparent pressure to change the focus and therefore, the structure of the Balint group in its entirety, rather than subtly modulate the process.

Traditionally, the Balint format we typically adhered to included one presentation followed by a phase of enquiry, a 'push back' phase and later, a discussion divided into the patient's and doctor's perspective. The doctor would then return and continue the discussion until the hour was up. We had historically adapted the original Balint structure to suit the psychiatric trainees in their first year of training. As such, we make an explicit division of the discussion time between exploring the patient's perspective and the doctor's perspective. This division is designed so trainees can attend to the patient amidst their enthusiasm to support and think about their colleague's experience -often an identified-with view.

In the face of lockdown restrictions and almost overnight, our Balint group moved from real to virtual space. With this, we felt invited as group leaders to

[4] Salinski, J. (2009). A Very Short Introduction to Balint Groups, The Balint Society, https://Balint.co.uk/about/introduction/ [accessed 28 August 2020].
[5] Sklar J. (2018). *Balint Matters: Psychosomatics and the Art of Assessment*. London: Routledge.

change the group structure, externally by participants and internally by our felt pressure to respond. There was hope that the format could include direct support for doctors, with space to discuss their own worries about the virus.

It was tempting to do so, and it even felt depriving to deny our trainees an opportunity for support. Nevertheless, we felt there were significant risks in changing the Balint structure, and instead, listened to the implicit request for flexibility.

But what could the group be risking? We hypothesised that unstructured Balint would encourage a predilection for the doctor's perspective in the doctor-patient dyad. Watchful of the socio-political climate, we felt there were external and internal pressures for the doctor to be idealised; the reticent soldier who braves great danger and hears clapping feels they cannot protest. Changing the format as an informal source of support would likely deepen this state of idealisation. This could shield the doctor from recognising their negative counter-transference, a vital source to their patients' own challenging experience.

How We Proceeded as Group Leaders

The situation was complicated, and the function of the Balint group became more important than ever, reflected in the consistently high attendance of participants to the group. This made it necessary that we, as group leaders, questioned our rationale for what we were doing and, more importantly, reflected on the group's performance and the trainee responses. To this end, we held near-weekly post-group leaders' debriefings to discuss the constant evolution of the process, its impact on the doctors, and how we both felt about it. We used our debriefing sessions to track the evolving themes of the group and contemplated how the external reality bore resonance with group themes illustrated later in the essay.

By tolerating our own guilt about not creating a peer support group, we may have actually *supported* our doctors to stay with feelings of guilt, shame and helplessness,

enabling them to be more receptive and empathic to similar difficulties faced by their own patients. As such, ongoing consideration of the parallel process was paramount. Instead, we responded to requests for flexibility by making nuanced changes of the Balint experience. We endured the rise of the informality of initial virtual Balint sessions, made concessions for more generalising comments, and after sessions spent a few minutes to reflect on aspects of technology and check-in with trainees. This preservation of the structure with out-of-session modulation allowed for space to consider the doctor-patient relationship without neglecting the increasing needs of trainees under pressure. We encouraged a meta-emotional position, gently encouraging doctors to connect with how difficult thinking about their patients can be, in a pandemic that threatens the doctors arguably more than their patients. We hoped to reduce the likelihood of acting out, such as becoming frustrated with patients, or striving to provide idealised care that could be unsustainable and risky to the doctor.

By adhering to a predictable structure, we were able to tease out difficulties in the doctor-patient relationship during the COVID crisis. Challenges were observed in the ways doctors approached a structured Balint session, the flow of discussion as well as the content of the discussion.

Themes in our Balint Group during a Pandemic Lockdown

'Balint groups themselves can be influenced not only by individual stories told in the group but also by agents from the outside, such as external traumas'.[6] Attentive to this, we tracked themes of discussion during COVID-19, linking possible associations between difficulties brought by doctors, with those encountered by the nation. In other words, the intertwining of internal and external reality being played out in the doctor-patient relationship. While this cannot be proven, the

[6] Rabin. S, Maoz. B, Elata-Alster. G. (1999). Doctors' Narratives in Balint Groups. *British Journal of Medical Psychology*, 72: 121-125

reproducibility and structure in the Balint sessions helped disentangle some central dilemmas, and comparisons were made with contemporary articles, to help with tentative links.

Difficulty Keeping the Patient in Mind When the Doctor Feels Threatened

An initial theme was the difficulty of keeping the patient in mind when the doctor felt physically under threat. This took place in the initial phase of the lockdown, as deaths from coronavirus were counted daily, and the physically vulnerable were asked to isolate. It coincided with the initial requests for a change in the Balint format to become more unstructured and alike to a peer support group. Examples of this theme included cases in which the patient's family member, and not the patient, became central in the discussion or cases when minimal history was known, and the focus was more on the doctor's own state of mind.

Feeling Trapped: The Hero Doctor Needs Rescuing

Another theme that emerged and was sustained during the pandemic was the perception that doctors felt trapped, basking in idealisation but then trying to maintain this position at the expense of their own health and anxiety, as well as their loved ones. Links could be made to external realities such as the idealised weekly 'clap for our carers', running in parallel with worries about vulnerability and uncertainty, such as the lack of personal protective equipment (PPE), changes to psychiatric training progression and medical redeployment. An example of this theme was a case when a therapeutic boundary (such as clinic time) was breached with a patient who maintained a praising position of the doctor.

Closeness at a Distance: The Neglectful and Infective Doctor

Further to this, themes of doctors juggling closeness and distance from patients to maintain idealisation became prominent. Being an 'ideal' doctor was difficult to

define because the quality of the disease was seen to *infect* the quality of the dyad relationship. On the one hand, the doctor could risk killing patients by transmitting COVID-19 in attempts to care for them. Conversely, keeping a distance from patients (physical distance and wearing masks) equally threatened the idealised doctor position, with doctors worrying about being 'neglectful'. Both stances brought about feelings of guilt and helplessness. Around this time, while the death toll continued to rise, there were significant anxieties about vulnerable doctors and patients. Namely, anxiety about lack of testing & PPE with reports of healthcare staff dying of COVID-19, concerns about making difficult end of life decisions and advice not to engage in a patient's resuscitation without PPE.

The Despair of the Psychiatric Doctor in a Pandemic

The height of hopelessness and sense of futility peaked shortly after the Prime Minister was admitted to intensive care. During this time, doctors in our Balint group discussed cases featuring the futile role of a doctor in a time of an incurable illness, specifically the sense of uselessness of psychiatrists in a time of physical disorder and limited ability to use their skills of communication, as physical barriers such as masks and distance impeded this. This was a time of introspection in the group, questioning the role of a 'doctor' in society and coming to terms that the doctor has limitations, and can only try to be 'good enough' with the patient.

The Guilty and Criminal Doctor

Another recurring topic included the doctor testing boundaries of reasonable force and interference in the patient's life. There was anxiety about becoming a coercive agent by ill-judged use of the Mental Health Act while at the same time worries about breaking the rules and becoming guilty of a crime. For example, considering legal measures to stop infected patients from leaving wards. This frozen state of confusion coincided with public confusion over the present and future with regard

to COVID-19. There were concerns about the public breaking the law and interpretation of lockdown practices could vary. Arguably, there was a national atmosphere of paranoia that one could be caught by the police and charged with a crime. Tentative plans about lifting the lockdown were uncertain and, with it, a sense of 'bated breath'. If the lockdown was lifted, was there hope at the end of the tunnel or was the country risking a 'second relapse'?

The Doctor Tends to Injuries

As the 'NHS Clap' was gradually discontinued, themes relating to the collapse of idealisation emerged. There was some focus on doctors experiencing racism or xenophobia, which paralleled the general perception that the virus was a 'foreign disease' not belonging to the West. Cases towards the end of this period also featured the doctor's guilt at 'overlooking' the psychiatric care of their patient as their attention had been directed towards COVID-19. Indeed, there was a concern about a growing 'silent pandemic' in the mind of the public. As the hope for an easing of the lockdown into the so-called 'new normal' grew, so did the anxiety about the 'indirect' costs of the virus on health and society as a whole.

Anxiety and Resistance Within the Group

As anxiety rose about the role of the doctor in the pandemic, we noticed a rise in tendencies to avoid denigration. Within the group, this could become a difficulty in selecting cases to present, difficulty in thinking about patients' perspectives and non-attendance. Resistance in the group was felt in the more informal and dismissive approach towards Balint, which became prominent during the time of highest anxiety about COVID-19.

There were also instances of the group wanting to discuss more than one case, reflecting the unmanageability of intense emotions evoked in the doctor. In

these cases, the leaders had to empathically encourage the doctor to stick to one case.

Lastly, anxieties about being viewed as an actively 'infective' or 'neglectful' doctor led to descriptive styles that were heavy in medical terminology and lacked warmth possibly masking, thereby, the underlying anxiety. At times, doctor-patient interactions were stripped down and focussed on sole clinical decisions, with language becoming technical, blunt and with little nuance. In these cases, doctors agonised over their guilt about actively harming and conversely, neglecting patients in their attempts to be helpful doctors.

In turn, we responded to the group's dismissive style and observed our own counter-transference. One of us wished to thank participants for joining the Balint group despite everything, in the desire to demonstrate that Balint was helpful and a wish that doctors would continue to attend. The other fought feelings of irritation at periods of informality in the group, and tried to bear a more flexible structure in view of the changing circumstances. During sessions in which a blunted affect predominated, we could feel emotionally cut off, and occasionally boredom crept in.

Over time, the group became more contained as all members grappled with the evolving circumstances and the new format. We noticed it became more 'alive', with language moving from the more distant technical and classificatory to the more metaphorical and emotionally laden. This helped engender honest discussions and with this, more tolerance of a 'less than ideal' doctor and patients with limitations and struggles themselves.

Virtual Balint: What Was Missing?

Moving to a virtual space was a new experience for everyone, and we were curious about its potential impact on the Balint experience. There were technical features

that helped to emulate Balint, such as 'hiding self-view', having a 'virtual' waiting room or turning off the doctor's camera in the 'push back' phase.

It is hard to pinpoint exactly why the virtual Balint felt different, but it did! We were left wondering about what is lost when there is no physical copresence, and instead, the group meets as disembodied entities. Gillian Russel, in her elaborate study of screen psychotherapy, invited us to consider the impact on learning and memory when she pointed out that "the embodied experience of acting and moving in space is connected to learning, mental processing, and memory. Movement and the three-dimensional qualities of physical co-presence may make a greater and more lasting impact on memories".[7]

We ended the group with a sense of personal satisfaction, having managed to carry on the group through a difficult time. Our trainees valued the group and provided positive feedback, nevertheless, we were left feeling that something was lost when togetherness was shielded by the screen. Did the absence of essential external security impinge on the internal security of the group?[8] Has the temperament of our digital medium and its occasional tantrums limited our ability to provide a holding function as group leaders?[9] The latter factor, we wondered, forced communication to be much more explicit at the expense of implicit less cognitive interaction[2] and we found that it was harder for the group to be natural and spontaneous. The free-associative flow in the group became rather constrained.

Despite the physical distance and difficulty in free association, there was a curious contrast of greater intimacy, at times bordering on intrusiveness.
One experienced faces as closer, and by seeing into members' homes, there was access to mundane yet intimate details. At times, the personal sphere encroached on the group flow, with external noises such as the local bin collection, or the

[7] Russell, G. I. (2015). *Screen relations: The limits of computer-mediated psychoanalysis and psychotherapy*. London: Karnac Books.
[8] Parsons, M. (2014). *Living Psychoanalysis*. East Sussex: Routledge.
[9] Balint, M. (1979). *The Basic Fault*. London: Tavistock.

accidental flip of the camera focussing on the foot of the - at least consciously-unaware trainee... The group experimented with muting themselves to limit background noise, but the unnatural silence was soon felt to hamper spontaneity and free flow of discussion even further.

It is possible that the lack of our physical presence impacted on how safe members felt, and how vulnerable they allowed themselves to be. Although small shifts were noted over time, the quality of containment in a challenging time may have fallen short, or taken longer to establish.

Togetherness Lost in Silence

Silence experienced in virtual Balint felt different. As if we no longer shared space of contained meanings, yet to be expressed.[10] In an embodied group, the silence does not have a world of its own, but it can feel like a shared experience for group members. Each member floats in their internal associative process but has an awareness of togetherness and takes on unconscious responsibility for silences, by the physical presence of other members.

In virtual Balint, it felt as if there was little pressure to break silences. There were moments of unity in the group, but we learned they were held by a fragile thread, susceptible to rupture once silence crept into our virtual space. Speaking up did not seem to originate from an unconscious wish to relieve the anxiety in the group. Instead, it often reflected a conscious decision to be responsible for the interruption in the group and say something 'typically' appropriate and fitting to the moment.

As group leaders, we often wondered aloud to the group about the significance of silences for the patient and the doctor, but these searches for unspoken meaning were rarely fruitful. Instead, it felt like we were hitting a tough membrane[7] enclosed around each group member, too dense to penetrate or to allow

[10] Sabbadini A. (2004). Listening to silence. *British Journal of Psychotherapy*, 21(2):229-40.

a free flow of ideas. Reflecting on the situation in our debriefing sessions, we sensed a parallel process happening with us. Just as the group struggled with disconnection, we were perhaps, excessively curious about the silences.

Maybe we were anxious to keep the group alive, far from the deadening and detaching quality of these silences. Our inability to fully connect through the (virtual) spaces was something we felt as a moment of mourning, which we could not make up. Something had been lost by the absence of bodies in shared spaces, and it could not be retrieved!

Concluding Remarks

Safely tucked in rear headquarters, it can be easier to spot how the *external* reality of the doctor's working conditions and public sentiment during the COVID-19 pandemic intertwined with their *inner* reality. We hope that our account reflects the interweaving that took place and the impact it had on the doctor-patient experience. In a time of compulsory heroism, encouraging doctors to tolerate feelings of guilt, shame and helplessness, may have helped them in becoming more receptive and empathic towards similar difficulties faced by their own patients, in the present and future to come. As for technology's role, the jury is still out; surprise and gratitude that it allowed us to help doctors think about their patients, tempered with – dare we say it – a feeling of a *less than full* experience of being in a Balint group. Even though this particular journey has ended, we hope this account, alongside many others, can map out further understanding in this era of virtual exploration. For now, we long for a time of embodied spaces, perhaps also in a wish to ward off death and call for life.

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