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Musings on the Evolution of a Balint Group Leader: From Crisis to Consciousness

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"Psychotherapy is, above all, not theoretical knowledge but a personal skill" (Balint, 1964).

Most people do not intend to end up in rehab for alcoholism. It was certainly not in *my* life plan. Having been raised by an alcoholic mother, I felt myself rather above all that. However, during the second year of foundation training, I found my usual confident, friendly and out-going self being gradually eroded and replaced by an anxious and alcoholic replacement.

I was working in a busy Intensive Care Unit in a district general hospital. Having trained and worked as a psychiatric nurse prior to medical school, I found it incredibly difficult not to bond closely with my patients and their, often distraught, relatives. I simply could not see them as "the appendectomy in Bed 2". To me they were part of a family, a community. This was both a blessing and a curse. As one young woman said to me one day, as I approached the bedside of her dying husband, "I only cry when I see you". My holistic approach was good for families but bad for me. Being a perfectionist suffering with perpetual imposter syndrome (I was after all "not clever enough to be a doctor" according to my A-level teachers), I always took the sickest patients each shift and strove to cure the incurable on a daily basis. Gradually as the weeks went by, my nightly alcohol intake increased in order to drown the sorrow of the deaths and life-altering disabilities I was so frequently encountering.

After a particularly harrowing death of a young mother, with the screams of her four small children still echoing in my ears, I gave up trying to control my

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alcohol intake and plunged headlong into alcoholism. Thankfully, I had the insight to know I was in trouble. I went off sick and approached first the British Dentist and Doctors Group then the Practitioner Health Programme who promptly sent me to a rehab in Wiltshire. Once there, the true extent of my depression became apparent and I spent the next 14 weeks in rehab very unwell.

I firmly believe that had there been a Balint style group based in the ITU where I could have deconstructed my experience and gained the support of my peers, I would not have become as ill as I did. My ITU clinical supervisor was a compassionate and thoughtful man but I could not confide my distress to him as my peers all seemed to be coping so well. At the time I wanted to pursue critical care as a career and I thought it would go against me if I let him see my distress.

Psychiatry called me back to it and as a new registrar, I found myself back in the same hospital in a liaison psychiatry post. As the team was based in the emergency department, I had ready access to the junior doctors. I was determined to prevent anyone else suffering as I had for want of a space to reflect on their work experience. After three years of fortnightly Balint groups during my core psychiatry training, I felt that I had the necessary skill to start and facilitate a group of my own. So, I used my special interest time to set up a Balint group for the foundation trainees and senior house officers working in the department.

As I write this just over two years later, I smile as I think how naive and unexperienced I was.

The group was, and still is, held on a Wednesday afternoon during the trainees teaching programme. It happens sporadically and infrequently. There is a great deal to learn in emergency medicine and I am given slots as and when there is a gap. It lacks the regularity of my core training group but I am grateful to the consultants for every hour they give me with their junior doctors.

Each group lasts an hour and is attended by 10-12 doctors. My fellow participants are at various stages of training and specialty. Many are on a General

Practice training scheme, some are future ED consultants, surgeons or anaesthetists and many are too junior to have chosen a career path yet. The group also includes members of the armed forces as it is based in a tri-service hospital. The doctors rotate on a 6 monthly basis and there have been 4 cohorts through the group so far. In each group, roughly a third will have experienced Balint training before having completed a psychiatry job. The majority, however, have never done any sort of group like this before. It makes for an interesting, lively and anxiety-provoking mix.

I begin each set of groups by explaining via a handout the basic tenants of Balint work. I also ask them to complete a short questionnaire with the aim of attempting to justify the group to their seniors by demonstrating an improvement in their wellbeing or empathy with patients. This questionnaire has not been brilliantly helpful and in many participants it has actually demonstrated worsening wellbeing by the end of the rotation. As the groups are so sporadic, I suspect (and hope) that this is due to the stressful nature of the job rather than the uselessness of the group. The comments section at the bottom has been insightful, however. Almost all participants want to continue attending a Balint group in their next job and most have found it valuable. Phrases such as “really helpful” and “very useful” come up frequently. And many trainees express surprise that despite being “someone who is not normally keen to share emotions or personal experiences” they have enjoyed the group and found it supportive.

In the first session, I set the ground rules of confidentiality, punctuality (this is not very successful as trainees finish off odd jobs before teaching) and choice. I am very clear that there is no register of attendance. I ask them to try one group. However, if they then feel their hour would be better spent relaxing in Costa with medium cappuccino, I will neither be offended nor inform their bosses. So far no one has taken me up on this!

These days, I always rearrange the room, pushing the tables back and arranging the chairs in the traditional circle. In the beginning I tried having groups sat around the table as that is how the room is laid out, but it was not successful and I quickly learnt that the table is not just a physical barrier but also a barrier to contemplation. I have always permitted eating and drinking though I know this is not always allowed. This is their one time to eat – and eating is important to promote wellbeing, too. I have experimented with having the presenter sit out of the group and with them remaining in. I am still unsure about the merits of each, but I find that by not permitting them to speak, the group is forced to speculate on the case rather than ask the presenter to fill in the gaps. So, this is my current preference.

My favourite group with each new cohort is always the first one. I observe with an inner smile the expressions of terror when I say we will be discussing "feelings", the dawning realisation that if nobody speaks I intend to sit with them for an hour in silence, the inability to tell their story without commenting on the patients white cell count or ECG result, the relief when someone finally speaks and realises their colleagues empathise and relate to their case. The lack of judgement. The settling into a safe and containing space, maybe for the first time in their medical careers.

I am privileged to have been present when trainees have shared very difficult situations, where things went wrong or they made an error. Problems in the doctor-patient relationship when they judged a situation wrongly or where they experienced a negative outcome. Recurring themes are patients with mental health issues, substance abuse problems, self-harm, sexuality and gender differences and how these may obscure the human being behind the complaint and seduce the doctor into missing important diagnostic information. I am repeatedly humbled by the bravery of my peers in sharing their challenges with the group. It

is a delight to watch as new ways of seeing arise and the human being behind the label of "patient" emerges.

The group has challenged me too in many ways. When I started this endeavour I had no leadership training beyond being part of a group myself. I made many mistakes. I am a natural talker. I have a tendency to interrupt, to fill silences, to be intolerant of uncertainty, to find boundaries difficult to maintain. I had to learn to be still and listen more actively.

The group was also a trigger for my imposter syndrome, my low self-esteem and my poor self-worth. I did not choose psychiatry as a career. I chose emergency medicine, prehospital care, critical care medicine. Psychiatry chose me. It grabbed me firmly and tightly and I could not shake it loose. I constantly worried that my peers were doing the "real" work of doctoring while I was "just" a psychiatrist. Sometimes, this was triggered by a person in the group who would sit, leant back in the chair, arms crossed, looking bored, refusing eye contact. I am a master at mind reading (!) and I would just *know* they were thinking how pointless this process, and by default the whole of psychiatry, is. This is still a work in progress and I suffer this still after every group.

I also worried that I was not knowledgeable enough and that I was missing the deep psychoanalytic insights that were being raised in the group. Throughout this process, I have been sporadically supervised by more than one supervisor. More than once I have wished one of them were leading the group instead of me and felt guilty that my peers were missing out. When I began the group I believed I was just about qualified to be a leader. My supervision sessions frequently call this into question. I gain new insights with every conversation and frequently wish I had had my supervisor in the group with me when the issue arose. I grow in psychological mindedness as (I hope) the trainees grow alongside me.

One of the biggest challenges of this group is that I am asking my members to look deep within themselves, to confront "personal conflicts and difficulties, of

(their) unsolved and often unconscious problems" (Balint, 1968). To become sensitive to their own automatic patterns, to have an emotional response to their patients. To examine difficult transference and counter-transference issues. Tears are not uncommon. Realisations occur suddenly and painfully. Then, they go back to work. Straight into a busy emergency department working at full tilt. The work for me is to find the balance between allowing insights to arise, emotion to flow but stability and resilience to remain.

I am now attempting to become an accredited Balint leader which has been rather curtailed recently by the covid crisis. I have attended one leadership day in London and plan to attend several more when they restart. I joined a Balint group which plans to meet several times a year headed by a psychoanalyst. I have asked to join the supervision group which will meet online. I had the pleasure of presenting my group at the Tavistock to members of the society and I look forward to the conference even though I will be attending from my kitchen table.

I am not a brilliant Balint group leader. I am, quite possibly, not even a very good one. I know from the feedback I receive from junior psychiatry doctors that I am considered respectful, empathetic and kind. That I am able to provide a safe space for them when needed. That I am trustworthy and supportive. Despite my worries about my worth, I choose to believe that this is a good place to start. That these qualities stand me in good stead as I continue practicing holding space for my ED doctors as we explore together the doctor-patient relationship and attempt to find the common humanity within us all.

I will never know the impact of my work on these doctors. I choose to believe that the group helps them to grow in knowledge of themselves and their patients. I hope that their patients experience a more therapeutic and empathetic response from the participants. I hope that they become more curious and tolerant in their interactions. And, as well as this, if I can spare one person from experiencing some

measure of the agony I experienced eleven years ago as a result of my work, then I will be satisfied.

That will be enough.

I will have been enough.

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