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A Medical Student's Experience of Balint

Balint Society Essay Prize 2020 Joint Winner - Student

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Introduction[1]

In selecting the student selected component this year, I felt inexplicably drawn to the Balint project. Balint represented an opportunity to consider my interactions with patients or those between patients and doctors that left me feeling stuck, conflicted, or unsettled, without clarity about how to process the experience and integrate the learnings into practice. The importance of empathic awareness is impressed upon us constantly in medical training, but to date, much of this has focused on formal training in communication skills, which although essential, has often neglected the subtleties of the relationship that could not be taught didactically but that are painstakingly acquired though practice and reflection on such practice. Balint represented an opportunity to develop self-awareness and to more deeply consider the doctor patient relationship and the potential dynamics that drive it. In this essay I describe my experience of adapting to the Balint approach, the process of examining many of the assumptions and unconscious biases I realised I held, the benefits and constraints of my role as a medical student and how the Balint group safely held a place for vulnerability in practice.

Balint Process

Although I approached Balint with some understanding of the purpose, the method was elusive initially and I found we spent much of the initial sessions debating the facts and merits of the case, which while interesting, did not materially alter our understanding. In much of our medical training the process is deductive and largely prescriptive. The Balint process was the antithesis to the "expert's mind" we had been cultivating, requiring instead a "beginner's mind", which values uncovering what is not known and which expresses an openness to multiple

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possibilities.[2] We were regularly reminded that our feelings, impressions, and fantasies were considered key to understanding the case. While this requirement to suspend logic and rationale and place myself in the experience of another person was not entirely unfamiliar, for me it was a question of having permission to work in this way. I felt that I was being asked to go off piste, to draw on the assumptions I was constantly being cautioned against, to consider multiple possibilities rather than identifying the right one, to use the facts of the case not to draw reasonable conclusions, but as a spring board to the various unconscious processes driving the interaction.

Furthermore, it was suggested repeatedly that the most valuable work would come from exploration of our "fantasies" with respect to the case. This required "flights of imagination";[3] a leap of faith that required us to imagine a patient's broader life and life history. I often found myself intensely uncomfortable when asked to speculate on what history or motivation could drive a person to behave in a certain way. I felt frustrated by the limits of the information supplied and stymied by my desire to ensure my own personal experiences and projections weren't creeping into my interpretation of events. Looking back, it seems impossible to think that I could have tried to circumvent any projections I may have brought to bear onto the work. Over time, I realised that I couldn't subtract myself from the process and that maybe it wasn't necessary to do so. At times, my fantasies were relevant, informative, and insightful; other times I'd reconsider my perspective in light of other more compelling contributions. Ultimately, I

[2] Courtenay, MJF. (1992). A Plain Doctor's Guide to Balint Work. *Journal of Balint Society*, 59(2): 183-185.

[3] Kulp, B. and Sternlieb, J. (2016). *Burnout, Balint Group, and New Beginnings: Unearthing the Next Step to Optimizing Triple Aim*. Poster presented at LVHN Research Scholar Program Poster Session, Lehigh Valley Health Network, PA.

concluded that to step into someone else's experience, I had to extrapolate, at least to some extent, from my own.

Over time, I felt there was a deeper understanding, both individually and collectively, of the requirement to fully inhabit the role of the actors in the scene by imagining what they might feel and experience. As we gave ourselves permission to go with our instincts, fantasies and feelings, the whole group came alive. There was a noticeable shift in the energy of the group. It felt less clunky, cerebral, intellectualised and effortful, yet paradoxically far more real. It seemed easier to speculate, unravel personality differences, motivations and upbringing when I no longer felt tied to getting it right. There was often a specific point in each case, where a feeling, an image or a fantasy would be contributed, and I could feel a tangible upswing in the engagement and energy of the group. It wasn't so much that we'd cracked the case, but rather that one of our fantasies had a certain resonance to it, or that there was some joy or satisfaction in making a connection no matter how seemingly small, about an interaction that had been previously unresolved.

This process required a degree of disinhibition and courage and I appreciated the honesty and willingness of our group in divulging all the stark and uncomfortable aspects of cases and our personal reactions to them. In the beginning I was perturbed by constant reminders to use the word "I" but over time realised that this had two effects. It ensured I spoke for myself and therefore owned my own experiences. Secondly, this holding of my own experience surprisingly made me feel more confident about it as I didn't need to put it forward tentatively not knowing if it applied to others or had their approval. Furthermore, I hadn't considered how using "we" exerted a subtle effect. Over time I found myself resisting it as it didn't always apply to me. This was described as the "collectivising" of a group experience and using the word "I" promoted specific and idiosyncratic responses to the source material and allowed for the uniqueness

of different positions to emerge. This was key as these discordant voices were often those that radically altered my understanding of a case or shed light on something that had previously eluded us.

Another aspect of this willingness to engage with the uncertainty of the process was receptivity and openness to feelings, imagery, metaphors and analogies which arose. For me these explained the essence of cases far more holistically than debating why a situation was jarring or difficult. I realised that much of my information came from the physical experience in my body which told me something about the possible feelings that were present at the time e.g. when a presenter described working with a patient she felt manipulated by, I felt trapped in the room. In one of the cases the facilitators pointed out that the pace of contributions seemed defensive, as if we were avoiding getting too stuck into the feelings and experience of the case. I realised this mania and chaos reflected the case, where a patient, relative, doctor and student were trying to work through a long incomprehensible list of clinical complaints using a scatter gun approach, seemingly to little avail. These experiences highlighted how what happens in the group often reflects the experience of the case, and also that I could use my physical experience and the feelings in the room, both proactively and retrospectively, to understand a case.

I also found imagery immensely helpful in making a sense of experiences I had struggled with. In a case I brought I had felt disturbed by an interaction between a patient and a doctor. I described the doctor as a fairy, batting cases away with a lightness of touch I both envied and distrusted. Exploring this imagery enabled me to get a better grasp of the case and my disquiet, and also helped others in my group to visualise my experience to help me work through it. This openness to playfulness meant that sometimes the left field view, metaphor or analogy was the key to energising or redirecting the discussion e.g. a complex case with an abusive patient made much more sense when we considered it as a stage

performance, with curtains, an audience and various actors playing different characters at different times. Although these ideas seemed wacky and eccentric, they deepened our understanding of the case as well as enabling us to see the humour in it, painting a picture that we could explore, build or reject to get under the skin of a case.

This process highlighted the merits of multiplicity; although affirming the commonality of experience was reassuring and validating, the diversity of the group meant that there were a myriad of perspectives and possibilities brought to light in considering cases. Before Balint, I used to take solace in the idea of our similarity. However, in many cases, hearing the contributions of those who saw it differently resonated better than my initial impressions of a situation and I found myself learning more from these alternative perspectives e.g. understanding the pressures on a surgeon in a case, or re-evaluating my potential contribution as a medical student. I found that over the course of a discussion my reactions changed to a case; not because I had adopted another person's perspective, but more that through the evolution of the discussion I had a different feeling about the individuals and the situation, or perhaps a more rounded one.

Confronting my biases

For me, the diversity of perspectives was instrumental in challenging some of the most firmly held assumptions I had that were potential barriers to effective practice with patients. I realised in presenting a case to the group that my own biases had come into play in my struggle to relate to a patient with a needle phobia. The group's exploration of the case made me appreciate the myriad of reasons that may have caused the patient to be fearful and to present late, and the possible reasons for the less instrumental approach taken by the doctor. This made me reflect on the nature of the interaction and how doctors have to meet patients where they are at and manage their own state consistently to be able to do so. I had worried about

the requirement for constant adaptation to different patients, but I realised during the evolution of our discussion that it's possible to do this and still be authentic; that these connections are just as meaningful despite the absence of any assurance of sustaining them. This case made me explore my ambivalence about this work and also some of the unconscious biases I had about a style that was different to my own.

Related to this, much of the discussion in Balint gave rise to reflections on what constitutes a "good doctor". In describing a case that involved two consultants with opposing styles, I had erroneously assumed that the more affable doctor was the most competent one, more able to build a rapport with the patient and elicit relevant information. It was a reminder of my bias in preferring doctors with a style similar to my own and accrediting competency accordingly, and that there are likely multiple approaches and personality types that can all work effectively.

This theme recurred during Balint and I noticed that many of the cases involved narratives where doctors had demonstrated disregard for patients, sometimes even seeming callous in their approach e.g. disregarding the emotional aspects of an attempted suicide presentation or reminding a terminally ill patient they are the cause through their lifestyle choices. Despite my initial anger, reflecting on these cases with others enabled me to understand the feelings and experiences driving the doctors in these situations. Despite not condoning their behaviour, I could appreciate the frustration, the desire to have patients take ownership for aspects of their health that could affect change, a sense of weariness after years of similar cases, the desire to focus on whatever pragmatic actions may yield guaranteed results, as well as the undeniable experience of holding ultimate responsibility for decisions pertaining to patients' treatment and case management. In one case a participant described her fantasy regarding a surgeon called to assess a surgical patient who was acutely unwell. She explained how a degree of self-

protectiveness may be required; how a surgeon literally has their hands in the patient's body, and while consciously they may know that there are many reasons why patients don't recover, ultimately surgeons must feel a great deal of this onus of responsibility. If surgeons see countless patients daily, perhaps they can't afford to worry about every last outcome, otherwise it would be impossible to do the job. I realised that this is not so much about detachment as about having boundaries, and this explanation radically altered my perception of the surgeon's approach to the case.

Another aspect that was reflected on was the experience of the patient. The Balint experience brought home to me that when we hear patients' medical histories, we are hearing their stories too and that there is something quite intimate about this. These interactions though brief, inevitably constitute part of the therapeutic process. Part of our role in treating patients is to do what we can to restore them to equilibrium, and also as health professionals, to hear the impact of that loss of equilibrium on their lives.

This raises the question of what treatment is and the concept of the therapeutic contract. I realised that there are both explicit and tacit expectations embedded in the therapeutic contract; that we give patients time, privacy and protect their interests. Similarly, we expect patients to have treatable conditions and instances where this isn't the case, for example, a functional disorder, can be far more difficult to negotiate and may bring up our biases or helplessness in not being able to effect any change. That unidentifiable yet palpable connection that happens between patients and doctors or students feels like the key thing that makes that encounter successful and examples of profound connections described by participants made me question the limits of my influence as a medical student.

Reflections on being a medical student

One case brought by a presenter described how his rapport with a patient was scuppered due to the presence of the patient's parents. This gave rise to discussions about the contribution of medical students and the extent to which we can assert our boundaries. This reminded me of previous situations where my perception of my lack of knowledge and status prevented me from asserting myself or requesting support, despite knowing that when I do ask for help the learning has been tremendous. Thus, my sense of my own insignificance has been disempowering, causing me to subjugate my needs and disregard the contribution I make. I realised that my perception of my own significance tips far more than just one case, it influences and shapes multiple interactions that can determine both my learning and the formation of effective and authentic relationships with others.

Related to this conversation around boundaries and needs, I realised that its permissible to dislike patients, uncomfortable as this may be. A case of a patient with a conversion disorder brought home the frustration I've felt when I couldn't relate to a patient or get a clerking on track. This reminded me how obstructive my own highs standards can be and how my expectations of perfectionism permeate not just my own experience but my interactions with others, and how sometimes I need to be more accepting of mistakes and inexperience, and courageous in seeking support.

One case we explored involved an attempted suicide which the doctor addressed in an entirely detached and pragmatic manner. The presenter felt prevented from connecting with the patient due to the doctor's approach. This case highlighted the extent to which I feel I can be authentic with patients. On my GP placement I rotated across 11 doctors and noticed that I often mirrored the relationship the doctor had with the patient i.e. exhibiting friendliness or a more formal approach depending on the style of the doctor. I felt to behave differently would be inappropriate or an invasion of the doctor's relationship with their

patient. This could be quite disempowering and listening to the approaches of others I realised this experience was not entirely universal, but might be a matter of perception and the indelible sense of hierarchies which pervade all clinical environments and are at best implicitly sensed and at worst explicitly reinforced. I realised that perhaps there is a middle ground; interacting with the patient but maintaining an awareness and respect for the primary relationship between the doctor and the patient.

Vulnerability and safety in practice

A key realisation in the Balint group was that the learning required a degree of openness and vulnerability and this vulnerability could be safely held by the group and the facilitators. Part of the benefit of Balint was not having to pretend to be impervious to all our experiences with patients, particularly the emotional aspects of the work which could be moving, painful, difficult or scary. In one of the cases the presenter described a very profound connection with a patient that left her feeling the need to conceal her emotional reaction to the experience. It reminded me of a similar experience with a terminally ill patient and I was left considering the degree of vulnerability allowed or disallowed in clinical environments, where issues of life and death are encountered daily. It showed me how sometimes strength can lie in vulnerability as it enables me to be open and connect with others, and also of the importance of having a safe place to process such experiences.

Conclusion

The benefits of my Balint experience were far reaching; supporting me in grappling with difficult cases and generating explanations that allowed for a deeper and more compelling understanding of the agendas of doctors, patients and medical students, and the dynamics underpinning these relationships. The differing perspectives challenged many assumptions and biases I was unaware of, including

an appreciation of styles different from my own, an acknowledgment of the value of my contribution as a medical student, and my indisputable right to boundaries and support. The experience gave me insight into why I've experienced seemingly innocuous interactions as challenging for reasons not fully understood or openly navigated. There was also an acknowledgement of the power I hold when I'm attuned, and how sometimes seemingly inconsequential actions, such as truly connecting with a patient, potentially make all the difference; a sense that although treatment includes the use of medication, the actions associated with its management go far beyond it.

All of this was aided by the inductive nature of the process in Balint. Here there were no clear diagnoses or treatment plans, and learning to use patterns, connections and insights from the case material enabled me to understand experiences at an unconscious level [4]. I found it liberating that energy was less invested in figuring out what was right and wrong about the case, but rather the feelings and motivations that underpinned the actions and reactions of the different players. I felt this approach brought a case to life and I found it liberating to engage aspects of myself not usually mobilised, relying on instincts, feelings, fantasies, and metaphors to get beneath the thin veneer of explanations I had reverted to at the outset. This process gave me an insight into how to access and use my feelings in a more constructive way; without being steeped in emotions and using them to usurp reason, but rather as a reminder to check in with myself and reflect, an approach for managing vulnerability constructively and navigating the inevitable difficulties, joys and challenges inherent in the doctor-patient relationship.

[4] Suzuki, S. (1970.) *Zen Mind, Beginner's Mind*. New York: Weatherhill.

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