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A Curious Case of Countertransference: Reflections of a Junior Psychiatry Trainee

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Setting up for my first medical student Balint group of the term, I felt quietly confident. I rearranged the tables and chairs – carefully set out in neat rows facing the screen – into our usual circle, and turned off some of the harsh tube lighting, trying to make the room feel slightly less 'clinical' – somewhat of a challenge in a hospital.

With my UK Balint society leadership training fresh in my head, I felt an excited anticipation at what this group might bring. I remembered the challenges I had faced leading my two previous groups, reassuringly shared by my peers leading similar groups: poor attendance, uncommunicative students, a limited tolerance of silence. My co-leader, a fellow core psychiatry trainee, and I had navigated these issues with the support of our supervisors and the groups had responded well. Nothing I couldn't deal with again, I thought.

As the students slowly filed in to the room, I was shocked – there were so many of them! A scramble to find more chairs quickly ruined the calm and collected first impression I had hoped to make. As expected, the students looked clearly perturbed at the circle formation waiting for them. They exchanged some anxious glances and nervous laughs as they took their seats, and I tried not to appear too flustered, aware of the twelve faces now turned expectantly towards me. Of the twelve, I noticed there were eight men– not a gender ratio we are familiar with in medicine these days, especially within psychiatry.

The students had had their introductory lecture, so after a brief recap of the structure and rules, I opened the floor to any potential presenters. I was met by the usual downcast eyes, shuffling of feet and silence, but eventually one of the

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students came forward and presented her case. A consultant had invited her to sit in on a clinic. The first patient presented a valuable learning opportunity, the student was told, due to the presence of acute psychotic symptoms. The patient, having initially said he did not want a student to sit in, grudgingly withdrew his objection when the consultant explained the importance of teaching about mental health. The student felt very uncomfortable, believing the patient had been left with little choice, and had not truly consented to her being there. She wondered whether the patient was too unwell to fully understand her role, and worried her presence may have intimidated him, as he was not very communicative during the consultation.

This case brought up some common themes from medical student Balint groups, well documented in the literature (Torppa et al, 2008; O'Neill et al, 2016). I found myself thinking about how we might best explore the idea of patient and doctor 'sides', and the medical student identity. I foresaw a familiar discussion about the feelings of uselessness often encountered by medical students, as they perceive themselves as almost parasitic, leeching off the patients they clerk in for their portfolios, or the consultations they witness, and mistakenly feeling they can offer nothing positive in return.

As the student was presenting her case, one of her peers started eating a packet of crisps. Very loudly. As she was still presenting, another got up to re-fill his water bottle from the nearby sink, which involved walking directly through the circle to the other side of the room, and back again to resume his seat. How rude! I thought. How disrespectful!

As the discussion began, I was unprepared for the intensity with which some of the students attacked (the only word I feel really does the process justice) the case. This was clearly an opinionated group, who were not afraid to challenge each other. While this made for a lively discussion, the students were soon talking over each other and I felt the situation was rapidly spiralling out of control. I started to

feel warm, and noticed my palms were sweating. Most of the group fell silent as four of the most outspoken members moved on to the topic of the patient's capacity. We suddenly found ourselves discussing hypothetical 'what if' scenarios involving refusal of life saving treatment in a military situation – how on earth did we get to this? There was a sense of trying to find the 'right' course of action, with two students dismissing another's suggestion as 'wrong'. In trying to encourage the students to consider other perspectives, I found myself getting drawn into the discussion. I tried a different tactic, gently bringing the patient and the case back into the picture, but the students continued with what was quickly turning from discussion into debate.

Noticing the increasingly shell-shocked expressions of some of the silent members of the group, I decided it was time to intervene more firmly. Thanking the students for their input, I noted we had digressed somewhat from the case, and suggested we think about things from a different angle: how might the patient have been feeling in this situation? I was completely ignored by one student who appeared to have appointed himself group leader. 'Come on guys, what are the ways in which we define capacity?' I was speechless.

Eventually, we found our way back to the case, and discussed some more familiar themes. Had the student considered her presence might have been reassuring for the patient? After all, we knew very little about him. What part did the consultant play in all of this? The session finally drew to a close.

As the students filed out, I stayed seated for a while and tried to make sense of what had just happened. My overwhelming feeling was of anger. The arrogance, the presumption of those students! I had never experienced anything like it. I couldn't stop thinking about it over the next few days, and although the initial emotions settled, I was left with a feeling of anxiety. Did I do something wrong? What could I have done differently? How was I going to stop this happening again?

Having had a week to digest my thoughts, and still struggling to make sense of things, I attended supervision with mixed emotions. I hoped the discussion with my supervisor and peers would give me some clarity, but in the back of my mind I worried that I might be judged negatively: had I overreacted? Had I just handled the situation poorly? As I gave my account, I was comforted by the raised eyebrows and incredulous gasps of my peers. It was nice to see people bristling in the same way I had! The acknowledgement that this had been a very difficult situation came as a flooding sense of relief, and I felt some of my anxiety ebbing away.

My supervisor was particularly interested in this anxiety I had been left with – what was that about? I tried to articulate it: a sense of loss of control perhaps, a deviation from the predictable towards the unknown. A deeper worry that I was not good enough, not up to the task; the old 'imposter syndrome' rearing its head. And then, a simple question, but a powerful one. How did I think the students might have been feeling? That clarity I had been hoping for suddenly presented itself – having been so caught up in my own anxieties, I had been unable to see how closely these might have been mirroring those of the students. Was the act of nonchalantly eating crisps in fact an attempt to break some of the tension? Was the student leading the capacity 'tutorial' just trying to regain some control over an unknown situation, an unpredictable learning environment? The hypothetical scenarios, the right and wrong thinking; were they simply ways of trying to categorise things neatly into familiar boxes? I felt overwhelmed, and a little chastened – the students' arrogance had been anything but.

To have had this learning experience so early on in my training I think is invaluable. We are primed to notice transference and countertransference during our interactions with patients, but I had not considered how important a role it might play in this setting, or indeed others. I have since found myself thinking about MDT meetings, peer teaching sessions, with more awareness and a greater

understanding. I hope that this is something I can continue to carry forward into my clinical practice.

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