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Unspoken Valency and Showing Emotion

Balint Society Essay Prize 2022 Winner – Student

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'Communication is the heart and art of medicine' (Ha and Longnecker, 2010). It is also a skill that requires honest self-reflection to hone and understand. Although I had never heard of the Balint Society before, I selected the Balint group project because of its focus on reflective learning. I was interested in the possibility of exploring the medical student–patient relationship and reflecting honestly on the various dynamics and driving forces that steer such interactions. Reflection is necessary for any medical practitioner to develop and improve professionally. It is thus of paramount importance to succeeding in all aspects of medical practice.

In medical school, my teaching regarding empathy has been focused on how to offer verbal empathy to a patient, and not how to feel it oneself, nor on how to reflect upon feelings of empathy. This difference is important. Empathy is integral in effective patient–doctor interactions – however, without reflection upon how the doctor feels, the empathy can degrade and become disingenuous. Reflection improves the quality of the empathy the patient receives and in turn improves the ability of the doctor to cope with their emotions, consequently enhancing the doctor's mental health.

This essay will begin by briefly outlining the Balint process. My discussion will be divided into two themes: unspoken valency and the appropriateness of showing emotions. Finally, I will reflect upon my experiences in this Balint Group and comment on Balint's overall usefulness for my future career.

The Balint Process

In this section, I touch on five aspects of the Balint process. To begin, I offer a summary of the process. I then consider my role while listening to cases and while presenting. I touch on the dynamics of my role and finally review my reflective journey.

My Balint group had eight members and two leaders. We sat in a circle every Thursday evening for 12 weeks. Each week, one presenter volunteered to speak from memory about a significant interaction they had experienced with a patient. The interactions had remained with them, often because they were emotive experiences, or they felt unable to process the interaction. After the presenter finished their case summary, the leaders invited a limited number of questions, generally no more than five from the group. The presenter was then required to remove themselves from the group discussion, whilst the group discussed the case and its nuances. When each aspect of the case had been explored, the leaders invited the presenter to return to the group. The group then had an opportunity to reflect on what they had heard and offer feedback if the presenter felt that would be helpful.

In the early stages of the process, there was a palpable reluctance in the group to disregard the clinical facts of the case and to examine the emotional responses of the subjects in the case study. Indeed, I felt this approach was contrary to much of my academic teaching, and I found it unsettling to think about medical situations from a more subjective, rather than a factual scientific, perspective. It took time for me to give myself over to the process.

A few weeks into the project the leaders encouraged the group to fantasise, to go with initial thoughts and run with our imagination. It felt wrong initially to speculate about others and the motives which may have driven their actions. Over time, I found exploring these fantasies helped greatly. It was a way of allowing my emotional imagination to drive my thought process, and it enabled me to verbalise these thoughts back to the group.

While listening to cases toward the end of the process, I realised that thinking about patients as human beings, as people outside the consultation room, was very important in allowing me to relate and empathise with them. When I could paint a clear visual picture of the patients, I was then able to relate to them

on a deeper level and thus be more empathetic. I found that when the presenter was able to share additional aspects of the patient's lives (such as their profession or social circumstances) it enabled me to understand and resonate with them more. I found throughout the project that when I presented a case, I not only shared my memories, but I shared myself: the principles by which I conduct both my professional and my personal life. This very personal, open contemplation was only made possible by the safe, non-judgemental space created by the two leaders. An important part of fostering such an environment was the mutual recognition of the need to maintain the confidentiality of the meetings.

My role in the group varied week by week. Sometimes, I felt a synergy with the case and very connected to the patient. On these occasions, the process flowed easily, as did my contributions. However, on other weeks, I found visualising the patient difficult, and relating to the case was consequently challenging. During these weeks, I found myself in awe of the others' contributions and their ability to grasp the case. I also found it comforting to hear others depict cases where I had experienced a similar interaction. They were able to verbalise emotions that I had not yet considered or thought to reflect upon. I felt a bond between us as medical students during these shared experiences. It was reassuring to hear the others' struggles and concerns because it meant I was not alone on this journey, in the challenging environment that is medicine.

Finally, I'd like to comment on my reflective journey and how it formed my now more holistic viewpoint. Through Balint I have been encouraged to and become familiar with seeking a wider breadth of insight into situations. I was comforted at the beginning of the process by hearing the others' points of view that aligned with my own. However, with time, the opposite became true. The varied contributions of the group members, especially those which made me reconsider my preconceptions, taught me much more about my own perspective than the contributions that echoed my own thoughts. The Balint group allowed me to foster

a more balanced and reflective outlook. The opposing opinions were vital, enabling me to reflect more deeply. The Balint group facilitated an approach that incorporated multiple perspectives, whilst giving me the space to visualise and collate ideas for improved interactions in the future. I believe learning and continuing this type of rounded reflection will make me a more balanced, well-informed clinician in the future.

The Unspoken Valency

Unspoken valency was a concept introduced to the group by the facilitators. It is the unrecognisable pull between a patient and a medical student, a synergy that would not have been the same between two different individuals in the same consultation. Unspoken valency is a notion I had never considered in the context of a doctor–patient relationship prior to my time in the Balint group. Upon reflection, while presenting the following case to the Balint group, I truly understood its importance and how much valency alone can drive a consultation.

During my General Practice rotation, I met a man in his forties who had migrated to the UK from Bangladesh. I was asked by the GP to take a history and consider a management plan. After less than a minute of us talking, I realised his mood and demeanour was very subdued. His eyes darted around the floor, he was slumped in his chair, and he was speaking very softly. Without thinking I put my book down, where I had been taking notes, and closed it. I no longer required my lists of signs, symptoms, and differential diagnosis, to feedback eventually to the GP. This case was dissimilar to others I had encountered, and I intuitively began to operate differently.

My change in behaviour was picked up on during the groups reflections and this subtle action was described as a symbol of presence. By closing my book, I gave

myself over to the patient and was actively present in the consultation. This behaviour gave me presence and allowed me to see the patient as a whole, as a human being, someone with a life outside of the room. This patient was not suffering from an organic medical cause which could be neatly categorised but was rather an anxious and depressed individual. To help this patient effectively, I needed to learn more about his life and his social background and to discover what had led him to visit the GP that day.

It transpired that the patient had migrated to England due to being persecuted in Bangladesh for his sexuality. He was seeking a new life, one where he could be himself without fear. However, he had been finding things difficult and freely admitted to feeling suicidal regularly. Before this consultation I had not had a one-to-one talk with a patient about suicidal thoughts. Nevertheless, I was settled by his ease in opening up to me and I felt very comfortable talking to this patient, despite my lack of experience. Much of the group's discussion revolved around valency. The group considered the unrecognised pull between the patient and myself. The group commented on a palpable connection between the two of us – something I had not considered before.

I am part of the LGBTQ+ community. On further reflection, I think this played an important role in the consultation's dynamics. Neither the patient nor the Balint group knew this about me, yet still the group noticed a synergy between us. I felt a deep sadness for the man's situation and could not help but imagine the hardships he had suffered. I felt a strange sensation during the consultation, almost like an unconscious pull towards him. Unspoken valency is an intangible, but very powerful force, which can drive interactions with patients. This force is what I believe allowed the patient that morning to feel listened to and it allowed me to be non-judgmental and sympathetic. I now have a better grasp of myself and how my everyday life will impact my future consultations, unconsciously pulling me towards patients, or potential pulling me away from them.

After this interaction, I reflected on the support in place for GPs after they have cared for suicidal patients. Most patients that commit suicide consult their GP at some point before their death (Rotar Pavlič et al., 2018). This is rarely spoken about, perhaps due to a level of guilt or deep shame that GPs may be burdened with. I think many GPs rely on informal self-help strategies from family, friends, and colleagues to cope. Balint groups, however, can act as a different type of professional support.

The group's discussion surrounding this case did delve into the worrying emotions students or doctors are left with after seeing a suicidal patient. The group posed questions about what medicine really is and whether the mere presence of a compassionate doctor may act as a therapeutic benefit to the patient. It is very hard to accept that sometimes sitting and listening is the best therapy for patients. I found it valuable to hear from the group that it is sometimes all one can offer, and that I am not always going to be able to resolve every problem I encounter. Accepting that 'the doctor is the medicine' is challenging because of the weight of responsibility this carries, but in many cases such as this one, it feels applicable and comforting to know the support this can bring (Balint, 1955).

Is Showing Emotion a Sign of Weakness?

Since starting medical school, I have learnt that a career in medicine comes with an emotional burden. However, before participating in this group I had not considered the tools needed to cope with that emotional stress. In what follows, I explore coping after an emotionally demanding patient consultation through a discussion of a case review. I then discuss grief and burnout.

One highly emotive case was discussed a few weeks into the process. The student had met this patient, a woman in her fifties, whilst on a GP rotation and

was tasked with taking what seemed like a relatively straightforward pain history. However, one week prior to the consultation the patient had survived a catastrophic house fire, leaving the family homeless and her son hospitalised. The presenter became visibly upset whilst recalling the events and reliving the story. The student mentioned she had not been this upset when reflecting on it before. She was shocked and apologetic about her emotions. The group was supportive and attempted to reassure her that it was natural to feel emotional.

This case expanded my insight into unconscious parameters that can increase emotions and make it harder to cope with patient interactions. When the presenter re-entered the discussion at the end, they recounted a time their mother's dress had caught light whilst cooking. They had not thought about the significance of this near miss in relation to the patient before the Balint group. The 'what if' scenario that may have unintentionally been playing in their head about their own personal experience perhaps made this patient's grief more meaningful and tangible for this student.

The Balint environment is a unique space where one can bring traumatic stories and reflect on them free of guilt, without the worry of burdening friends and family. It is an environment that reveals the truth of the cliché that 'a problem shared is a problem halved'. This reaction from the student presenting illustrates the benefits that may arise from reflecting on one's emotions. I suspect that if the student had not had the opportunity to speak about their feelings, they may have found them harder to come to terms with.

As to the emotion of grief, it was a feeling that was touched upon in many of the twelve cases presented to the group. For many weeks I danced around the topic, not wanting to highlight its presence, through a fear of then having to discuss it. Grief is very personal and effects everyone in different ways. However, it does inevitably affect everyone. A leader commented one week on the group's hesitancy of the topic and queried why. The silence was broken by an admission from

someone that they had a preconception that doctors should be strong. This then led the group to consider the appropriateness of crying whilst at work. I found it hard to accept that doctors could listen to patients relaying trauma and stressful events whilst remaining entirely unaffected themselves. I commented during the group that while it is acknowledged that patients may require counselling to address their trauma, there remains a feeling of discomfort in the medical profession around accepting that we may require therapy. I have accepted that I cannot always be strong, and I may cry at work. Indeed, it is sometimes acceptable – and even helpful – to do so (Robinson, 2019).

One role of Balint groups, described in *The Australian Family Physician* journal, is their potential protection against burnout and compassion fatigue (Benson and Magraith, 2005). 'Burnout' is defined aptly by Figley as 'physical, emotional and mental exhaustion' caused by being involved in an emotionally demanding environment over a long period (Figley, 1995). In contrast, compassion fatigue can come on suddenly and is a result of dealing with patients who are experiencing or have experienced stressful events. Compassion fatigue, if addressed in the primary stages, can be reversed and the professional can make a full recovery. Both can lead to feeling overwhelmed and helpless. Burnout, if not tackled, can lead to depression (Benson and Magraith, 2005).

In one of the cases presented, a doctor was described as treating a patient with contempt and disregarding a safeguarding concern. The presenter had raised this matter with the doctor and had also been dismissed. I found myself judging this doctor and I wished I would never adopt their demeanour in years to come. This fear of losing passion and drive for the occupation was echoed by the group. Now I think the doctor's concerning behaviours were signs of compassion fatigue. I wonder if the doctor in question is feeling the strains of their role more than most. So, their empathy and inner purpose has diminished. I feel this doctor, like many, could reap the benefits of a Balint group. Balint provides a safe environment where

viewpoints can be challenged, and positive encouragement given. Having access to this environment and being a part of Balint, I believe, can protect health professionals from compassion fatigue and burnout.

Conclusions

Overall, my experience in this Balint group has been very positive. I can see the many benefits this supportive group learning environment can bring. It gave me the opportunity to reflect upon my own challenging experiences and learn from others as well. I found it particularly helpful in consolidating my feelings about, and uncovering the driving forces behind, patient interactions. The group setting allowed for healthy debate and the varied viewpoints left me with a newfound appreciation for the value of holistic reflection. The environment created by the two leaders felt safe and secure, allowing me to express my emotions freely. I found it difficult at times to find the right words to explain how I was feeling. However, through attempting to verbalise and structure my thoughts, I was able to gain a deeper understanding of my emotions. I now feel more confident in trusting my instinctive feelings, accessing my own emotions, and engaging with them.

It is a privilege to be entrusted with information about patients' lives and guide them through their most challenging times. The role of a doctor is a daunting one because there are unavoidable trade-offs that will occur: with these gains there will be inevitable losses. I think such challenges are easier to come to terms with if they are foreseeable and reflected upon. The process has reminded me of the reasons why I chose this career and the phenomenal difference doctors can make to their patients.

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