Balint Groups to Address Countertransference and Burnout in Palliative and End-of-Life Care

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Introduction

Caring for patients with serious or terminal illness evokes powerful emotional responses in even the most experienced of healthcare providers. These reactions can trigger a cascade of clinical and behavioral responses from grief, irritation and avoidance, to deep affection, idealistic hope and over-involvement. When left unaddressed or unexamined, demoralization, burnout, and boundary crossings can result (Shanafelt et al, 2010).

To prevent this, it is important for clinicians to be aware of both the patient's emotions (Block, 2000; Meier, Back & Morrison, 2001) and their *own* (Katz & Johnson, 2006; Ofri, 2013). However, health care professionals are not always cognizant of the emotions and thoughts that can get in the way of their work with critically ill and dying patients and families (Weiner, 2006). These reactions may stem from individual countertransference conflicts and feelings or they may reflect normative reactions to life-threatening illness and mortality.

Whatever the origin, lack of professional self-awareness can contribute to disconnection from patient, family *and* self. This disconnection impairs the provider's capacity to be fully present to a plethora of patient feelings and experiences, frequently interfering with the capacity to be present to suffering, no less to attempt to address or relieve it. Non-mental health clinicians are particularly vulnerable, as they are often encouraged to put their feelings aside when working in stressful or emotionally charged situations. Palliative and end-of-life care is no exception (Weiner, 2006, Kearney et. al, 2009).

Clinician Know Thyself

In this era of quick fixes, financially-driven health care policies and high acuity work loads, there is little room, little time and little appreciation for the need to stop, take stock, evaluate and examine ourselves, our patients, our families and the systems in which we work. Efficiency is valued over process, definitive decisions over options and evidence based protocols over patient identified goals. Little value is placed on the internal emotional needs and conflicts of the health care provider and even less attention paid to the impact of these on relationships with patients and their families. Without attention to the interpersonal dynamics which inevitably surface in every provider-patient interaction, health care professionals are left in precarious situations cognitively, emotionally and clinically (West et. al, 2006). In recognition of these difficult dynamics and their impact on patient care, Balint groups were born.

Balint Group Beginnings

The era was World War II. The place, post-war England. The players, primary care physicians swamped with the psychosomatic and psychosocial complications presented by their patients as troops demobilized and the chronic costs of war set in. In witnessing the intense challenges imposed on their medical colleagues at this time, psychoanalysts Michael and Enid Balint (Balint, 1972) developed Balint groups to help primary care physicians deal with the nonmedical aspects of treating people with Post Traumatic Stress Disorder and other problems. The Balints understood that the interpersonal medium often carried the curative aspect of care, indeed that some patients might come needing the medicine of the doctor's caring respect (Balint, 1972, p.116). Accordingly, their case consultation groups were designed to help physicians focus on their doctor-patient relationships. To this end, Balint groups encouraged empathy and understanding of the patient, the physician, and the relationship between the two.

Today Balint groups have evolved to include health care and mental health professionals from multiple disciplines (Balint and Norell, 1973). They are in use in more than two dozen countries (www.balintinternational.com), both as training for professionals new to their fields as well as for ongoing support and development of experienced practitioners. Balint groups support and nurture the kind of searching self-reflection that leads to the self-realization of an empathic and effective clinician, i.e. a better clinician (Diaz, Chessman, Johnson, Brock & Gavin, 2015). Thus, they are especially well-suited to people who work in end of life care.

A Balint Group in Action

The following case, taken from a group of international participants, demonstrates what happens in a Balint group.

With the Balint group gathered one of the group's leaders asked for a case. A palliative care doctor shared the following. He worked as a consultant in a large teaching hospital and was called to help with a dying man when staff were in conflict with the patient's family. The doctor, a tall man of British heritage, entered the hospital room to find the patient, a twenty four year old Asian man diagnosed with late stage pancreatic cancer, disoriented, physically agitated and grimacing in pain. Over the course of his brief treatment, the patient had not managed his own care. His mother and father had made all medical decisions throughout his illness, and were now in his room forbidding staff from giving him the help they felt they could. A miserable-looking resident and an angry nurse stood outside the room.

Over a couple of hours of careful negotiation with the embattled parents and the dying son, the doctor won permission to order medication to ease the patient's agitation and pain. By the time the doctor's shift ended the patient was resting much more comfortably. Now, at this

international conference two weeks later, this presenting physician had been unable to get the case out of his mind. He did not know why and asked for the group's help.

The group discussed the case by imagining what it was like to be the doctor in this situation, what it was like to be the patient, and what the experience was like for the parents and others in the complex treatment context. They identified the doctor's helplessness, his sense of being an awkward intruder, and his burdensome awareness of the vulnerabilities and the palpable suffering in everyone he met on the unit that day. They spoke of the son's physical pain and his devotion to his parents. Several people noted that they considered his deference to them culturally normative for an only child of this age and heritage. They speculated that the successful, worldly son might have grown up being the bridge between his old-fashioned émigré parents and the English-speaking city in which they found themselves. They remarked on the reversal of this dependency during his final illness. The group members guessed that the patient knew he was dying but that he had hidden this knowledge from his parents in order to spare them additional anguish. Finally, the group speculated that the parents felt frantic and helpless and might be fighting misguidedly to protect their son because they found the whole situation so untrustable, so unacceptable, so unbearable. One group member noted that what dies with an only child may be a whole family, not just a single person. Other members imagined that this tenderhearted doctor felt responsible to several patients in this one consultation: the dying son, the parents, the troubled resident and maybe even the misattuned hospital ward itself.

The doctor listened to all this with interest, taking the freedom given him by the group to pursue his own thoughts and use what was said for his own purposes. In the end he thanked the group, admitted surprise at the complexity of the accurate picture the group members had been able to form, and said he had several new insights about the situation. He told the group that as a

result of listening to their processing of the case, he had decided to give a Grand Rounds on this case to help hospital staff with multicultural sensitivity. He did not explain any specific shift that had occurred during the group work, but felt sure he would no longer be haunted by the case. Waelder, (cited in Menninger & Holzman, l973, p. 94) observes that "since we are all partially blind, the best we can do is to support each other so that the vision of one may make up for the myopia of the other." Perhaps, for this physician, the Balint Group supported that vision.

Impact on Care

The sources of isolation for people who provide medical and mental health care are many: confidentiality prevents us from talking freely about the most important interchanges that happen in our days; the ways we try to make sense of things may be quite technical and this has a tendency to isolate us from our feelings. Finally, some of our truly intimate relationships may be with very troubled or unpeaceful people, so that their closeness is hard to bear.

Balint groups address all these sources of isolation. Access to peer support influences job satisfaction and the sense that one can sustain meaningful work (Kjeldmand et. al, 2004). Reintegration of affects and deepening self-awareness improve the practitioner's use of herself in work settings (Lichtenstein and Ludwig, 2006). And the original goal of the Balint group, improving doctor-patient relationships, means that the real human satisfactions of providing care are more available to practitioners. In essence Balint groups address Gabbard's (1999) premise that countertransference "is inevitable and useful as part of an exploration involving two spontaneous and responsive individuals engaged in an intense and emotionally taxing interaction."

Successful Balint groups require good leadership (Johnson et. al, 2004) to establish and maintain enough safety to open up emotionally. To this end leaders must instill strong norms of

confidentiality and respect. Balint groups are not therapy, so leaders must encourage deep reflection while respecting the limit of focusing on the professional self and not on the personal self. Optimally the groups also require steady membership and good enough frequency, at least once a month, for their 'dose dependent' effects to be felt. They have been known to continue for decades, perhaps the ultimate evidence of their utility (Salinsky and Sackin, 2000). Where there is risk of burnout, such longevity may also attest to their supporting and sustaining healthy careers.

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