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The Balint group experience for medical students: a pilot project

Sheila O'Neill^{a*}, Kirsty Foster^b and Alexa Gilbert-Obrart^c

^aGraduate School of Medicine, University of Wollongong, Wollongong, Australia;
^bSydney Medical School Northern & The Kolling Institute, University of Sydney, Sydney, Australia; ^cPrivate Practice, Sydney, Australia

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Loss of empathy has been reported in medical students as they move through the clinical phases of their training. Several researchers have attempted to address this issue by exploring ways of heightening students' awareness of the emotional, non-biomedical aspects of illness and the dynamics of the doctor–patient relationship, using a variety of reflective group discussion methods. This pilot project employed the specific group method developed by Michael Balint for general practitioners working in London after the Second World War. The pilot was based on one group of six third-year graduate students, meeting weekly over six weeks. Evaluation includes pre- and post-questionnaires, a 1000-word essay and leaders' observations. The results suggest that the traditional Balint method needs to be modified for students at a point in their training where they have not yet been exposed to patients for long enough to develop meaningful patient relationships. Nevertheless, there was some evidence of a heightened awareness of the dynamics of doctor–patient relationships and the importance of psychological/emotional factors (including their own prejudices) when interacting with a patient. Balint-style groups could be an effective way of encouraging medical students to reflect on the importance of emotions in the doctor–patient relationship.

Keywords: Balint group; medical students; doctor–patient relationship; group dynamics; empathy

Introduction

In 2009, Yale's Emeritus Professor Howard Spiro wrote: 'Empathy is the foundation of patient care and it should frame the skills of the profession. For clinicians, empathy is the spontaneous feeling of identity with someone who suffers. It is a comfortable emotion generated by interactions with our patients. Empathy can be curative or at least helpful for patients with the "existential pain" that comes from the troubles of living'.

Spiro's emphasis on the need for empathy, and his concern that it is being lost in the medical profession and, in turn, in our medical schools, echoed a growing

*Corresponding author. Email: sheila@impluvium.net

concern. Loss of empathy has been reported in medical students as they move through the clinical phases of their training, particularly when they reach the third year. 'The devil is in the third year', announced the title of a 2009 paper by Hojat and colleagues. Hojat et al. followed a cohort of 456 students at Jefferson Medical College at five time-points throughout their medical course – empathy scores remained unchanged for the first two years, significantly declined at the end of the third year and persisted until graduation, with no gender differences. (The third year of a four-year US and Australian graduate medical programme corresponds to either the third year of the typical UK undergraduate five-year programme, or the fourth year of a six-year course: it is the point where the students move into clinical rotations.)

Research suggests that the cause of this erosion of empathy is multifactorial: the pressure of the students' workload, the emotional distress associated with their first intimate exposure to illness and death, the junior status of students who may experience intimidation and even harassment by senior colleagues in the hospital hierarchy, the anxiety associated with early attempts at physical examinations and diagnoses, and the role models of senior doctors whose own apparent lack of empathy may be interpreted by students as an effective coping mechanism (Angoff, 2001; Hojat et al., 2009; Neumann et al., 2011; Pitkälä & Mäntyranta, 2004; Rhodes-Kropf et al., 2005; Sheehan, Sheehan, White, Leibovitz, & Balwin, 1990; Silver & Glick, 1990; Sung et al., 2008; Wagner, Hexel, Bauer, & Kropiunigg, 1997; Wolf, Balson, Faucett, & Randall, 1989).

Ironically, the current, well-intentioned crusade for 'evidence-based' medicine, coupled with rapid advances in medical science and technology, may have exacerbated the problem by distracting students from the need for an empathic encounter with every patient. Compassion can become the casualty of ever-more complicated clinical science. Marsh (2015) refers to the need for doctors to find the right balance between professional detachment and compassion, and describes this as 'a problem all doctors must face'. The danger, of course, is that the pressures of medical training and early-career medical practice may push students in the direction of detachment. Hojat et al. (2009) mentions the 'escalation of cynicism' and the 'atrophy of idealism' as long-standing problems in the formation of young doctors.

A number of methods to retain and enhance empathy in medical schools have been employed: improving interpersonal skills, being exposed to role models, facing hospitalisation, studying literature and the arts, cultivating narrative skills and participating in small-group discussion.

Several researchers (Shapiro, 2011; Shoenberg & Suckling, 2004; Yakeley, Shoenberg, Morris, Sturgeon, & Majid, 2011) have explored ways of heightening students' awareness of the emotional, non-biomedical aspects of illness and their impact on the doctor-patient relationship. Some have experimented with variations on the reflective group discussion method. In 2008, Torppa reported on the first qualitative analysis of the Balint method in the medical student context, involving nine female students over 15 sessions (the present study was based on a group of five males and one female).

Our pilot project initially employed the traditional method pioneered by Michael and Enid Balint for general practitioners working in London after the

Second World War. Michael Balint (1964) is perhaps best known for his assertion 'At the centre of medicine there is always a human relationship between a patient and a doctor'. Traditional Balint groups are case-based, seminar-style group discussions with 5–10 general practitioners meeting weekly for a 90-min discussion over a 2–3-year period. The groups are designed to offer a supportive, non-judgemental context for frank discussion of the emotional aspects of illness, both from the patient's and the doctor's viewpoint (including the effect of prejudice and preconceptions on a doctor's perception of a 'difficult' patient). Balint groups may help doctors and medical students overcome feelings of isolation and despair and encourage a greater alertness to emotional factors contributing to, or resulting from, the patient's condition (Sung et al., 2008). The discipline of a regular group meeting also helps to develop the habit of empathy and compassion and to improve clinical communication skills.

In traditional Balint groups conducted with doctors, discussion is limited to patient cases. In student groups, the themes discussed are often broader, with more emphasis on issues for the students, rather than an exclusive focus on their interaction with a patient, which, for students, is often limited and fleeting (Salander & Sandstrom, 2014; Shoenberg & Suckling, 2004). The duration of student Balint groups is typically shorter than for doctors, and leaders are often expected to be more forthcoming about their own clinical experience.

Additional issues unique to the student–patient and student–teacher relationship, such as negative role models, the search for professional identity, value conflicts and the need to resist cynicism have sometimes been addressed (Hojat et al., 2009; Shapiro, 2011; Sheehan et al., 1990). Thus, the student version of Balint has tended to blur the distinction between reflective group discussions and tutorials and, indeed, Balint groups have been used as an explicit teaching method for medical students in several European countries as well as the United States, Israel and Australia (Parker & Leggett, 2012, 2014; Perry, Lauden, & Arbelle, 2013; Salander & Sandstrom, 2014; Shoenberg, 2012).

In September 2012, a seminar was held at the Sydney Medical School Northern (SMSN), at which Dr Peter Shoenberg of University College London (UCL) was invited to describe his successful introduction of the Balint method to undergraduates in UCL's medical school (Shoenberg & Yakeley, 2014). Following the seminar, SMSN decided to undertake a pilot project with a group of graduate students in the school. This paper describes the results of that pilot project.

Method

The students for the pilot project were recruited via a personal presentation to the third-year class during orientation week at the University of Sydney's Northern Clinical School. The Sydney Medical Programme, in common with most other medical courses in Australia, is a four-year graduate degree. Students may be graduates of any undergraduate discipline but must have scored well in the Graduate Australian Schools Admission Test, which contains a science paper. Multiple Mini Interviews are also a part of the admission process. During the first two years of the

course, students study basic and clinical sciences intensively, combined with a problem-based learning curriculum. One day of each week is spent in clinical settings learning history-taking and physical examination conducted in small groups with bedside tutors. In their third and fourth years, students are in full-time clinical placements, rotating through specialties such as paediatrics, obstetrics and gynaecology, psychiatry and community practice as well as medicine, surgery and critical care.

The students in the present study, mostly aged in their mid- to late-twenties, were participating in the four-year graduate Sydney Medical Programme, and had just started their first period of full-time clinical placements. The Balint concept was introduced by SO'N and the objectives and requirements of the six-week pilot were explained by AG-O. Interested students were invited to contact KF, Sub-Dean of Education at the Sydney Medical School (Northern). Six students volunteered; five males and one female.

AG-O subsequently interviewed each student to establish personal contact and assess their suitability for group participation by exploring their background, their first degree and any previous study of psychology. During those interviews, students were briefed on the Balint approach and given descriptive written material (Salinsky, 2013; Suckling, 2006). Participants were asked to commit themselves to all sessions planned for the pilot project.

The group met on six occasions, at weekly intervals. Each session lasted for 90 min. The sessions were scheduled for the late afternoon, in order to cause minimal disruption to the students' other commitments. Each group session was facilitated by AG-O, a counselling psychologist and accredited Balint group leader/trainer, and co-led by SO'N, a medical practitioner engaged in clinical practice, teaching and medical research.

Participation in the project was on the basis of voluntary informed consent. As an evaluation of educational sessions, formal ethics approval was not required.

As part of the evaluation of the Balint group, students were asked to complete a questionnaire at the beginning of the first session. The questionnaire was adapted from Shoenberg and Suckling (2004), and was designed to explore the students' attitudes towards the student-patient relationship, and their expectations of this new component of the educational process. The questionnaire was re-administered at the end of the final session (with a refinement of the wording of one question). The students were also invited to write a reflective 1000-word essay on their responses to one of the cases discussed during the pilot project. All chose to do so.

As leader, AG-O initially followed the traditional Balint approach. At the beginning of the first session, AG-O outlined the structure and process of the classic Balint group, starting with the presentation phase ('Who has a case?') in which a volunteer describes an encounter with a patient that is continuing to occupy the student's mind either because it was puzzling or perhaps left the student feeling angry, frustrated, irritated, sad or in some other unresolved emotional state. The group would then enter the enquiry phase, when questions can be asked about factual details of the case, followed by the 'push-back' phase where the presenter

moves back from the group circle, adopting the position of listener/observer. The students would then be encouraged to explore the student–patient relationship aspects of the case, and to share non-judgmental speculation about the case/issues presented. Finally, the presenter would be invited to re-enter the circle and comment on what had been said about his/her case. It was suggested that two cases/encounters might be presented at each session. Ground rules about timing, confidentiality and mutual respect were also explained and agreed upon.

However, by the third session, it had become clear that the Balint method needed to be adapted, to meet the needs of students at this very early stage in their clinical training. While they appeared eager to present cases, they found it difficult to break free of the medical model, and to imagine themselves in the situation of another person – either patient or presenting student. Having not yet been exposed to a psychiatry rotation, they were clearly not accustomed to such psycho-socio-emotional reflection. For example, they struggled to consider psychological/emotional issues when a patient presented with acute symptoms, believing that their focus should be entirely on ‘solving’ the medical issue. This was understandable, given their very limited exposure to any individual patient as students new to the hospital setting. Members of the group tended to become uncomfortable when psychological factors were raised in the discussion. Indeed, they appeared to feel some antipathy towards a patient whose situation they couldn’t easily explain biologically.

AG-O therefore began the fourth session by convening a reflective discussion on the process itself. The students responded by stating that it had seemed unclear to them ‘what it was all about’ (for details of the nature of their confusion, see ‘Discussion’). Students pointed out that at this early stage of the clinical component of their course, they were rotating to a new medical/surgical team every four weeks, which made sustained follow-up of any individual patient difficult, if not impossible. They also reported that attending the weekly sessions on Tuesdays at 4.30 pm was logistically difficult, given their other scheduled commitments, especially when they had to travel across the city from different hospital locations.

Following the students’ feedback, the leaders realised that they needed to adapt the method to help contain some of these anxieties, by making supportive interventions designed to ensure that the students were better able to feel held by the leaders. These interventions generally involved the use of explanatory examples and insights based on the leaders’ own medical experience, together with explicitly empathic comments about the students’ situation. However, the essence of the Balint approach was maintained, including the ‘push-back’ phase, encouraging self-reflection and exploration of ‘meanings’ embedded in the encounter.

Results

Evaluation of the pilot project is based on three forms of data: the personal observations and interpretations of the two leaders (AG-O and SO’N), responses to the questionnaires completed before and after the project, and the reflective essays written within two weeks of the completion of the project.

Leaders' observations

All six students enthusiastically engaged in the group and attended all six sessions. They were willing, and even eager, to present cases. They appeared respectful of each other and supportive in their comments about each other's cases. It may be hypothesised that the level of mutual emotional support was partly due to the fact that the students were feeling the particular sense of vulnerability associated with entering the clinical phase of their training.

In the early sessions, students frequently spoke about the anxiety associated with the feeling that their role was 'neither layperson nor doctor'. Their contributions tended to focus on 'situations' rather than cases, often involving their own observations of interactions between other healthcare professionals, patients and the families of patients – particularly where these had challenged the students' idealised perceptions of how such relationships should be managed.

As the sessions proceeded, there were some signs of an increase in the level of interest in offering and exploring psychological insights and analysis. The discussion often moved in the direction of becoming more imaginative and exploratory, though there was a constant tendency to revert to the biomedical model as 'familiar' and therefore more comfortable. This also reflects the priority given to developing technical skills and knowledge at this stage in their medical education.

Even though these students were strongly predisposed to benefit from the sessions, it was clear that they sometimes had trouble getting to the sessions on time and 'switching off' from the pressures of their day's work. Time was needed to allow them to move into the more reflective mode of the group sessions.

Analysis of questionnaire responses

The responses were recorded on a five-point Likert scale; the point descriptions are self-evident from the following analysis.

(1) *I feel able to consider my clinical encounters in a new light.*

After the pilot, all six students agreed with this statement – none agreed 'strongly'.

(2) *I am becoming more aware of the significance of the relationship between doctor/student and patient.*

Before the pilot, one student was non-committal (neither agreed nor disagreed) and five agreed.

After the pilot, five agreed and one agreed strongly.

(3) *I am becoming more aware of the potential emotional meanings of some patients' physical symptoms.*

[NOTE: The wording of Q.3 was modified for the post-pilot administration: 'emotional meanings' became 'potential emotional meanings', and 'patients' became 'some patients'.] The decision to modify Q3 was made in response to our recognition that not all physical symptoms have emotional 'meanings' and that medical diagnosis is laden with ambiguity.

Before the pilot, three students were non-committal and three agreed.

After the pilot, one student remained non-committal, three agreed and two agreed strongly.

(4) *I feel the group was a safe place to express and process anxieties and frustrations about my work.*

After the pilot, all six students agreed strongly.

(5) *I am beginning to recognise the inherent value of the consultation itself.*

Before the pilot, one student was non-committal and five agreed (none agreed strongly).

After the pilot, five agreed and one agreed strongly.

(6) *I am beginning to appreciate the effects of my own humanity and personality on the patient.*

Before the pilot, one student was non-committal, four agreed and one agreed strongly.

After the pilot, three students agreed and three agreed strongly.

Would you like to be part of a Balint group in future?

Three students said 'yes' and three 'don't know'.

Should it be an integral part of the curriculum?

Again, three said 'yes' and three 'don't know'.

What did you find most useful about the Balint group work?

Four students mentioned being exposed to the insights, interpretations and perspectives of the other students. Two mentioned the value of the 'open', non-judgmental nature of the group – one identifying the particular value of the small size of the group. Two mentioned the opportunity for deeper reflection on the cases. One praised the value of the direction from the leaders. One appreciated the opportunity to 'unleash' difficulties encountered in clinical work.

What did you find least useful about the Balint group work?

Three students complained about circularity, repetitiveness and lack of clarity in the early sessions. Two mentioned time pressures, and the stress of fitting the group sessions into their schedule. One found nothing 'un-useful'.

Summary of students' essay themes

The six participants in this pilot project were invited to write a brief, free-form essay, reflecting on their experience as a member of the group, and on the insights, learnings or issues that arose for them from the Balint experience.

Five underlying themes emerged from the reflective essays:

- (1) Students expressed appreciation of, and enthusiasm for the idea of reflective group discussions about non-medical aspects of illness and their impact on the doctor–patient relationship. Typical descriptions of the group experience included such words as: interesting, enriching, secure, trusting, open and honest.
- (2) A primary effect of the Balint experience for these students was to confront and acknowledge their own prejudices and preconceptions. They wrote of recognising their own cynicism, insensitivity and even a certain callousness in their initial reactions to patients – especially those that fitted some stereotype such as ‘illegal immigrant’ or ‘drug user’. The group experience heightened their awareness of the hazards of stigmatisation. *‘It was not the initial presentation of her in hospital that really bothered me; she was a young lady that fit my stereotype of a drug addict; the facies of drug abuse and the crazy hair made her fit my mould of a patient who might be involved in drug use’.*
- (3) As part of the process of acknowledging their own prejudices and preconceptions, the students came to embrace the idea of ‘putting yourself in the patient’s shoes’ by trying to imagine what it would feel like to be that patient, in that situation. A key learning arising from this insight was that doctors must continue to offer the best possible care even to patients who have not taken proper care of themselves. As one student expressed it: *‘Cure sometimes, relieve often and comfort always’.*
- (4) At this early stage of their exposure to the work of medical professionals in a hospital, students expressed several reservations and concerns about ‘the system’. These concerns deepened as they practised the art of imagining themselves in a patient’s situation. They included: a lack of sensitivity to the patient’s need for dignity and respect; lack of time to devote to the personal/emotional care of the patient because of the pressure of ‘throughput’ standards, especially in emergency departments; a resulting potential for erosion of patients’ trust in the health care system. *‘I found the medical staff’s dogmatic adherence to the so-called “4-h-rule” in the Emergency Department unsettling. I believe such compulsion goes against what we are taught regarding “patient-centered medicine” and reduces our patients to jobs with deadlines rather than human beings with complex, physical, emotional and social needs’.*
- (5) The students were clearly fascinated by extreme, unusual or particularly challenging cases (amputation, drug abuse, non-English speaking patient,

illegal immigrant, etc.). Two important questions therefore arise: Did such cases make non-medical issues easier for the students to identify and explore? Will the students transfer their learnings from exceptional cases to more 'everyday' cases? A more prolonged programme of reflective group discussions would help in the process of generalising from specific cases by incorporating the Balint principles into every encounter with a patient.

Discussion

Although the reflective essays offered deeper insights than the questionnaires into the students' responses to this experience, neither source of data is sufficiently robust to allow confident reporting, beyond broad impressions and hypotheses.

Where pre-/post-pilot shifts occurred in responses to the Likert scale items, these were in a generally positive direction, suggesting that the students had perceived some value in the experience. Specifically, they had felt more alert to the impact of their own humanity and personality on the patient, confirming Yakeley et al.'s (2011) conclusion that a Balint-style approach can help students recognise and understand the emotions they bring to an encounter with a patient.

All but one of the students reported a somewhat greater appreciation of the potential emotional component of some patients' symptoms (although the change in the wording of this question might mean that students simply felt more comfortable agreeing with the second version).

Students were unanimous in their appreciation of the value of the group experience. They all reported finding the group a 'safe place' to share insights and observations. They indicated that for the first few sessions, the purpose of the pilot had seemed unclear to them (suggesting that the leaders had not been sufficiently clear in their initial briefing). By the fourth session, when the format was changed, they seemed to become more engaged and to both understand and appreciate the opportunity to reflect.

For medical students, the focus of reflective group practice is to begin developing the habit of seeing the patient as a whole person, to consider psychological/emotional issues, the sociocultural background and circumstances of each patient, and to acknowledge the concept of psychosomatic symptoms.

However, the students appeared somewhat equivocal about the practicality of integrating Balint groups into the curriculum, mainly because of the time pressures created by their existing workload (it is tempting to interpret the 'don't know' responses to the two questions about future Balint work in the questionnaire as being a polite way of saying 'no!'). While they enjoyed the opportunity to be part of the pilot, they believed that they would gain greater benefit from participating in Balint-style groups when they were sufficiently advanced in their careers to have more extended time with individual patients so that a true doctor-patient relationship becomes possible. Until then, their first priority appeared to be finding the emotional and physical resources to cope with their increased workload.

This problem is exacerbated by the fact that patients are being kept in hospital for shorter periods and are more likely to be acutely ill, while students' rotations are also becoming shorter. The combination of these two factors makes it hard for students to establish relationships with individual patients. Given the students very limited exposure to each patient, there was an understandable tendency for them to focus on the immediate need to exclude pathology, often at the expense of any consideration of the patient's emotional state or circumstances.

Students appreciated the opportunity to take part in reflective group discussion focusing on their experience in the clinical setting with patients. This was an unusual experience for them, given their busy graduate medical curriculum: the fact that they were prepared to travel considerable distances to participate in sessions at the end of a working day was an indication of the value they placed on the experience.

These results are sufficiently positive to encourage further exploration of the possibility of including reflective group discussions, based on the Balint approach, in the Personal and Professional Development programme of the medical student curriculum.

To be effective in enriching students' understanding of their own and their patients' emotional states and needs, any reflective group discussion must offer a safe and supportive environment, in which confidentiality is guaranteed: in general, the smaller the group, the more likely it is that this can be achieved. In the present study, a group of six students with two leaders generated effective group dynamics, with a high level of mutual trust. Clearly, if a group has too few students in it (say, fewer than six), any absences will have a correspondingly greater effect on the group dynamics. On the other hand, too many students can make the group unwieldy and inhibit frank disclosures. While it is regarded as conventional Balint practice to conduct a minimum of eight sessions with 8–10 participants (Shoenberg & Suckling, 2004), the constraints of the curriculum limited the present project to six sessions. It was logistically difficult to have the sessions run any longer than six weeks, which imposed an unfortunate constraint on the project. The leaders' view was that a further two sessions might have been beneficial.

The students in this pilot had all volunteered for the project and were therefore predisposed to benefit from the process. Even so, they had some difficulty incorporating the project into their weekly schedule. This suggests – as other researchers have also concluded – that such groups should only ever be offered as an option, and not included as a mandatory part of the medical curriculum (Parker & Leggett, 2012; Yakeley et al., 2011). Mandatory sessions risk being sabotaged by non-compliant students, who could be disruptive to the feelings of safety and confidentiality in the group. The Balint experience would also be of limited value to students whose own lack of empathy led them to resent its compulsory inclusion in the curriculum.

Balint groups are often moderated by two leaders. In the case of medical student groups, ideally one leader should be a trained Balint leader and one from a clinical medical background, as this facilitates identification with the students'

point of view. The limited evidence of this pilot study suggests that leaders of student groups should be mindful of the need for emphasis on extra support for the students, by being more actively involved in the process and by being more prepared for self-disclosure from their own clinical experience.

Students' generally positive response to the experience of this pilot may have been partly due to the leaders' modelling of empathic behaviour in a safe and trusting environment.

The value of introducing Balint-style groups into any medical school curriculum would be enhanced by an increased emphasis on the need to reflect on the role of emotions in illness and the dynamics of the doctor–patient relationship in more formal teaching settings – including lectures, tutorials, clinical rounds and mentoring. In other words, Balint-style groups would need to be part of a whole-of-curriculum commitment to a 'whole-of-person' approach to patients.

Limitations of the study

Since this was a small pilot study of six students over six weekly sessions, the data are insufficiently robust to allow extrapolation, beyond broad impressions and hypotheses. The leaders' observations and assessments of this project relied on process notes prepared immediately after each group session. Such notes are by their nature partly memory-dependent and may be influenced by the leaders' own (unconscious) prejudices and interpretations.

The study is further limited by the procedural change introduced after the third session. In effect, only three of the six sessions were sufficiently productive to permit evaluation of the pilot. Of course, there is a sense in which our evaluation of the first three sessions led to the enhanced productivity of the final three.

Although the entire movement to introduce Balint groups in the medical curriculum is based on the assumption that this will enhance medical students' feelings of empathy towards patients, the present study was unable to offer any insight on this matter. Its scope was too limited to permit longer-term observation of 'empathy-effects', and no formal attempt was made to assess participants' personal levels of empathy – before, during or after the pilot project.

Finally, the study is limited by the fact that participants were volunteers who were presumably already favourably disposed to the concept.

Conclusion

For graduate medical students, the clinical years are a turbulent period, generally involving a heavy workload and associated stress, increasing the possibility of a sense of insecurity and self-doubt. The experience of being totally immersed in clinical medicine and exposed to the complexities and demands of a tertiary hospital can be overwhelming – it is perceived by students as a 'sink or swim' environment and it is tempting for some of them to focus on 'external' sources of their

anxiety, such as perceived prejudice or social injustice (towards asylum seekers, obese patients, smokers and drug addicts, for example), rather than confronting their own insecurities.

They may also be disturbed by the experience of working in a hierarchical culture where neither students nor patients may feel sufficiently acknowledged as individuals:

As a student you learn to rationalise your fears and struggles and soldier on. By the end of the third year I am a person more concerned about which boxes of which form I can get ticked rather than engaging with patients – fear of exams, of angry surgeons, of night shifts and of looking stupid. Fear to engage with patients, to feel their pain and offer them comfort. (Henry, 2013)

Balint-style groups can provide an opportunity for medical students to recognise and understand the emotions aroused in clinical encounters, for both student and patient. While encouraging a heightened sensitivity to a patient's emotional state and life context, such groups can also encourage students, through practice, to better appreciate their own emotional responses to illness and to communicate more empathically with their patients, particularly through attentive, non-judgmental listening.

Confirming the work of Van Roy, Vanheule, and Inslegers (2015), it was clear from the present study that student groups require a modified version of the traditional Balint method. Leaders of medical-student groups should be prepared to accommodate students' need to discuss issues that go beyond specific cases.

Disclosure statement

No potential conflict of interest was reported by the authors.

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