

## Empathy Groups

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Empathy is a case of temporarily putting yourself in the other persons situation in order to try and feel how it actually is for them: what is actually at stake: what they are really afraid of; to sense how much it really hurts - both mentally and physically. Empathy within the medical profession can often be painful for the doctor.

### Empathy can be disturbed

When people are in deep crisis due to illness or fear and anxiety for illness - as well as mental and psychosomatic illness - we can attempt to repress, or dissociate from, *what is happening in reality* - in an attempt to avoid having empathy with oneself. We do this by either repressing, dissociating, bagatelising, reinforcing or pushing away the actual problem. In the doctor-patient-relationship the doctor often becomes involved in these coping/mastering strategies. The patient unconsciously avoids feeling *what is really happening*, attempting thereby, also unconsciously, to distract the floundering doctor. The doctor also becomes involved, however, because what is occurring on an unconscious level in the patient will be projected and can then be decidedly uncomfortable for him as well. The doctor works in a profession in which he is confronted on a daily basis with sickness, fear of sickness, death and fear of death. Even the strongest develop a thick skin in order cope with the constant contact with misery.

### Empathy Groups

I have begun to refer to the Balint groups as "empathy groups" (Thorgaard, 1998).

These are workshops, wherein doctors such as ourselves are slowly able to re-sensitise ourselves following the long and hardening process we endured in medical school and the subsequent years of clinical practice. The unconscious process of protecting oneself begins already in medical school: to be de-sensitised.

One develops survival strategies in order to avoid being constantly affected psychologically.

As doctors we always have to move on to the next patient, and then the next, and the next, and so on. Doctors become experts in diversions and conclusions. A certain amount of 'thick-skinned' approach becomes necessary. The risk is though that one develops a lack of sensitivity.

The process of re-sensitisation starts in the balint group. At the same time as working to sustain and regain empathy, development of tools - with which to deal with the empathy - are worked on, so that the doctor may be better at providing also patients with tools with which to deal with their lives more creatively and responsibly. Furthermore, the doctor attains more empathy with *himself* and is better equipped to behave more creatively and responsibly himself in the doctor/patient relationship. Participation in the balint group facilitates, in other words, psychotherapeutic skills, as well as enhancing skills in good doctor/patient communication, as well as self-care which has recently been confirmed in Dorte Kjeldmands research in Sweden (Kjeldmand et al 2004).

### Counter-transference as a tool

The term counter-transference embraces, in a broad definition, all reactions - conscious and

unconscious - in the doctor that interaction with the patient awakens. In the balint group the tools are the group's and the individual participant's so-called counter-transferences feelings and thoughts. That is to say, those feelings, fantasies and associations that are brought to life - partly in the group and partly in each member - against presentation of, and involvement in, a complicated doctor/patient relationship. Our book presents many clinical examples to illustrate this (Kaltoft & Thorgaard 2005).

### **Empathy exercises in balint groups**

There are six particularly exercises in which to instruct the balint groups. I call these exercises empathy exercises (Thorgaard 2005).

Firstly, it is in the presenting doctor's spontaneous comments about the patient, himself, and the relationship that are required as the foundation for group work. There is a great need for the doctor's emotional memory, and herein also the need for honesty and openness about the feelings and thoughts that being with the patient evoke and awaken in his or herself. The group's job is to reciprocate by responding just as honestly and openly with whatever the individual participant comes into contact with whilst listening to the case presented.

Secondly, it is important to inhibit the typical human urge to ask questions. It is important instead to express the thoughts, reflections, feelings and fantasies that lie *behind* the question one wanted to ask. Everything which lies in the otherwise invisible thoughts - and 'thought bubbles' (which always form both simple and complex questions) are far more useful for the group to hear in their efforts to be wiser about themselves and the problematic doctor/patient relationship being presented.

Thirdly, it is important to constantly *identify with* the colleague presenting the case. Asking the question, "how would I experience this if I were the doctor with precisely this patient?". When you put yourself in another's place, you are able to acknowledge the presenting doctor and assist with bringing his observations and feelings into awareness. One can also, perhaps, verbalise *that* which the colleague has unconsciously turned away from, as it was either too difficult to bear, felt as though the thoughts were wrong, was excessively taboo, or perhaps was simply too inappropriate to be able to deal with. The exercise can be an awakening process for both the presenter and the group as a whole. Many reactions to patients contact with us are universal.

Fourthly, it is a most useful exercise to attempt to identify with just how it is to be the patient in the presented doctor/patient relationship.

It is a mental exercise which is often extremely difficult for us doctors. How does/or did the patient actually experience me? I wonder how my voice sounds to the patient? How is to be in the patient's shoes in that situation we have both experienced?

Plenty of misunderstandings and blind alleys in the relationship, have their roots in that the doctor does not have sufficient insight into how the patient perceives him. One has not always *said* that which one *thinks* one has said. Furthermore there is the aspect that people have a tendency to believe that we are perceived in a certain way by other people - but we are often wrong. It is not uncommon that what we think of ourselves is rather our own ideal image of ourselves - instead of what other people experience when they are in contact with us.

A fifth, and useful recommendation is, that the group leader instructs the group, that following the short presentation from the doctor in question, is given leave to withdraw a little in order to listen to the group. In this way the group is encouraged to discuss amongst themselves rather than talk to their presenting colleague. In this way the colleague is relieved from the task of answering difficult

questions as well as explaining and defending himself so that he is far better equipped to concentrate on active listening, feeling and understanding. The presenting doctor may enter the discussion at any time.

A sixth suggestion is to keep in sight the fact that the doctor presenting often unconsciously treats the group, the group leader, or a particular group member in the same way as the doctor himself felt he was treated by his patient.

If the balint group and the doctor succeeds in regaining and sustaining empathy with the patient and doctor, then the patient may be met by his doctor in a new way. All changes in and between people occur in relationships. In complicated doctor/patient relationships it is rule of thumb that the doctor must change before the patient can. This was one of Balints great and simple observations: Changes and developments in doctor/patient relationships with complications often first occur when the doctor is able to take the first step.

### **The Unobjectionable Counter-transference**

Balint-work owes a great debt to psychoanalysis. Therefore a further jump into psychoanalysis: Freud (1912) spoke of the unobjectionable transference. I quote in my translation: "The key to the mystery is that the transference to the doctor is only suitable as resistance in treatment when it is either negative or positive transference of repressed impulses. When we make the transference conscious, we release these two components of the doctors emotional act: the other (third) component that is capable of becoming conscious and is unobjectionable, continues to exist and is, in psychoanalysis to exactly the same degree, the bearer of the result as in other forms of treatment."

The 'unobjectionable transference' is the patients contribution to, that an alliance in the doctor/patient relationship can come about. This contribution constitutes the ability to create personal contact to the doctor (and to other people) characterised by predominantly basic trust (Erikson 1950).

In a similar way, it is possible to isolate part of the doctors contribution - of counter-transference - which is unobjectionable and constitutes the doctors contribution to enabling the working alliance in the doctor/patient relationship.

The American psychoanalyst Harold Searles (1979) speaks about psychotherapeutic endeavours being present in human nature. These endeavours (attempts to improve our environment, (Winnicott 1947/1958, 1960)) are the most *essential part* of our intense striving to reach our fellow man, and is regarded by Searles as an almost universal 'drive'. This way of thinking can mean something for all doctors who enter into contact with patients and where the quality of the contact is partly the foundation for, and partly extremely conducive to any form of treatment. All doctors possess, to a greater or lesser extent, such a 'drive' to 'heal' the patient, and the patient in themselves! (Searles states that the basic therapeutic striving in people can be very much disturbed or impeded in the development, which in his eyes is a decisive contribution to creating and maintaining mental disturbances).

### **The Psychotherapeutic Motive**

Money-Kyrle(1956), discusses a normal counter-transference and describes two differing psychotherapeutic motives and processes. Firstly, a process whose motives are a discriminating mixture of *an interest in the patient* and *a desire to repair something* (striving to repair).

Moreover, he describes another consecutive part of the therapeutic process, where the motive is compared to a parent function because he sees it as the loving parents' unconscious identification between their own earliest self and their child. A healthy and creative narcissistic identification such as this constitutes for Money-Kyrle the basis of empathy. In psychoanalytic therapy this is known as *the*

*normal counter-transference.*

Here, we notice that Money-Kyrle introduces an important probing in the empathy concept. The previously described 'part' constitutes a fundamental striving in the search to identify oneself with another's development potential; that is to say, 'have another's best interests at heart' with 'therapeutic love'. (Little 1951). This 'part' of the essence of empathy doesn't say so much about '*how another specifically feels*', but it contains an ability for loving identification, which especially comes into its own and peaks when the other person is suffering. I call this fundamental part of empathy - inspired by Freud - the *unobjectionable counter-transference*.

### **Treatment Alliance, the Unobjectionable Counter-Transference and Contributing with Healing Love.**

There is, therefore, with the above observation, a part of counter-transference which is unobjectionable, and it is the therapist's decisive contribution to the establishment of the therapeutic alliance. The patient's contribution to the alliance is the unobjectionable transference. These two contributions in unison constitute the conditions for a therapeutic doctor/patient relationship coming into being. I have suggested that the definition of the unobjectionable counter-transference is *a basic ability and capacity, in many differing and extreme transference relationships, to maintain and regain the capacity to contribute with healing love.* (Haga and Thorgaard 2001) This is about liking, caring for and maintaining the ability - through identification - to actually care for the patient, even when they are difficult and demanding, angry and unpredictable - and on the whole just not very easy to like.

Much of what happens in complicated doctor/patient relationships is due to the doctor's unobjectionable counter-transference being disturbed by the influences of the patient. But paradoxically: It is precisely the expression of these disturbances that can tell the doctor a great deal about the patient's inner difficulties<sup>1</sup>.

Expression of the disturbances are often a way of indicating that the doctor has become involved in the patient's unconscious defence against inner conflicts and resistance (projective identification understood as partly resistance, and partly communication). One of the doctor's tasks is to familiarise himself with his systems of counter-transference disturbances. The work in the Balint group combined with the increasing and eventually comprehensive clinical experience with many different patients offers a unique possibility. Namely, to develop knowledge of how - and in how many ways - different patients (people) in different ways have an influence and impact on and disturb one's *unobjectionable counter-transference*. This then, in turn, allows access to the fact that the *professional personality* can be refined, individualised and made flexible in opinions and techniques in relation to each individual-unique - patient

By utilising a broad understanding of counter-transference, the group and individual members' counter-transferences become the tool. The group's work - through recognition and analysis of group members' counter-transferences - can lead to here and now changes in the presenting doctor's outlook and opinion of the patient. In other words the group investigates how the presenting doctor's therapeutic

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<sup>1</sup> ) Don't feel, feel how it is, feel how the patient has been treated, or how the patient treats himself, feel how everyone experiences and/or feels the patient.

endeavours become disturbed by the patients unconscious - via projective and introjective identification. Striving for re-establishment and maintenance of empathy - `empathising` - is a key area of the groups work. Group members are trained to feel, acknowledge and localise the patients disturbances of the unobjectionable counter-transference.

They develop an increasing capacity to endure counter-transference (Carpy 1989), to reflect about counter-transference, and to - reflected and well-founded – either intervene or refrain from intervening from the point of view of counter-transferences. The focus of the group on counter-transference analysis develops a means of nurturing empathy: the creative counter-transference.

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