ORIGINAL ARTICLE

Balint groups in cognitive behavioral supervision

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Submitted: 2020-03-05 Accepted: 2020-04-15 Published online: 2020-05-20

Key words: **Balint group, Balint method, supervision, cognitive behavioral therapy, therapeutic relationship, conceptualization, strategies, CBT supervision**

Act Nerv Super Rediviva 2020; **62**(1): 29–40 ANSR62120A04

Abstract

The Balint group, initially created as a psychoanalytical supervisory approach for clinicians to explore and express their personal experience in daily practice, can be successfully adopted in CBT supervision: assessment, conceptualization, intervention's finding, exploring the relationship and enhancing self-reflection. The Balint group, preferably consisting up to 16 therapists or students, takes place in a nighty minutes group format, with safe and emphatic, curious atmosphere during case explanation, questions, fantasies of the group about case, other essential persons and about practical solutions and reflection of the case presenter (protagonist). The group can achieve goals of CBT supervision using positives of group work and emphatic, less defensive and curious way. Although the Balint group have substantial cognitive work, emphatic and caring atmosphere, fantasies, but not statements, and emotional impact give experiential work features. This topic is less known in the literature of CBT supervision, yet from our personal practice can be an essential method of developing for the therapist. In the last few years, there have been efforts to evaluate the effectiveness of Balint groups of clinicians in changing their attitudes and values and preliminary results show increasing psychological skills, tolerance, and reflection in uncertain situations.

Introduction

CBT therapists often find themselves in therapeutic situations when they deal with problematic relationships with the patients, colleagues or supervisors, or those between patient and others. One method of dealing with more complex problems is through supervision or intervention within the Balint group (Samuel 1989; Kjeldmand 2006). The method was named after Michael Balint, a psychoanalyst and a doctor originally from Hungary. He and his wife Enid Balint started a series of seminars in London in the

1950s to help family physicians to reach a better understanding of what they called 'the psychological aspect' of general practice, learn and honing of "doctor skill". The method consisted of case presentation followed by a general discussion with an emphasis on the emotional content of the doctor-patient relationships (Salinsky 2003; 2013). Michael and Enid Balint were psychoanalysts, and they aimed to help family doctors to become more psychologically aware physicians. Learning to listen with close attention to what a patient was saying, was one of the most important skills which the early Balint group members were able to acquire – in a period when the teaching of what we now call communication skills was unknown. Michael Balint's book The Doctor, his Patient and the Illness (1957) became a key text in the renaissance of British General Practice in the 1960s and the Balint's' ideas achieved worldwide recognition (Salinsky 2003; 2013). Balint training method ''Balint Groups" became a traditional education method, well known and accepted professional development training worldwide. In 1972 the European Council recognized The International Balint Federation an as non-governmental agency which gathered national Balint societies from 21 countries (http://www.balintsrbija.org). Nowadays, the Balint groups spread in internet format (Lichtenstein, 2017). Later the Balint group were applied in the training of psychotherapists. This topic is less known in the literature of CBT supervision, the framework of the Balint Group is based on a psychoanalytic tradition but has also proved to be beneficial in supervising cognitive behavioral therapy by using the principles of problem-solving strategies (Prasko *et al.* 2012).

Michael Balint was a general practitioner who began to create workshops for other general practitioners in 1950 (Balint *et al.* 1966; Horder 2001; Kjeldmand 2006). He believed that, in addition to their medical expertise, physicians also needed to understand personality traits and use interpersonal skills to develop good contact with the patient (Stelcer 2011). He described the details and objectives of group supervision and intervention work in his book "The Doctor, His Patient and Disease" that was published in 1957. The method was developed for general practitioners (Balint 1964), which are still the most popular target group. The groups have been designed to provide practitioners with a platform to explore complicated patient interactions through case presentations and discussion (Novack *et al.* 1997; van Roy *et al.* 2015). The procedure involves peer support, gaining the views of other doctors in a highly effective and non-offensive form. From doctors, this idea has spread to psychologists, social workers, educators, lecturers, wherever the profession that requires to meet people and take responsibility for the interaction (Lustig 2006; Bar-Sela *et al.* 2012). The activities of the Balint groups have spread worldwide as one of the methods of continuous professional development of physicians and therapists (Salinsky 2002; Oppenheim Gluckman 2006). Some groups are exclusively for doctors or psychotherapists, while others welcome professionals from other helping professions (Rabinowitz *et al.* 1994; von Klitzing 1999; Dahlgren *et al.* 2000; Salinsky 2002; Graham *et al.* 2009). In some countries, this method is used as part of medical education or residential programs in family medicine (Musham & Brock 1994; Johnson 2001; Johnson *et al.* 2001; Johanson *et al.* 2004; Pinder *et al.* 2006; Torppa *et al.* 2008; Parker & Leggett 2014; Player *et al.* 2018).

In the last few years, there have been efforts to evaluate the effectiveness of Balint groups of clinicians looking for evidence of a change in attitudes and values participants of Balint groups. The preliminary results were described in the International Balint Congresses in Oxford, England (1998), Portoroz, Slovenia (2001) and later congresses. Results suggest that young family doctors who participated the Balint group were more psychologically skilled, accepted uncertainty when patient´s diagnosis was uncertain, were more reflective and more aware of their feelings about patients (Ludwig-Becker 1998). These doctors had a higher degree of career satisfaction, were more able to accept feelings of helplessness and were less probable to suffer from 'burnout' (Mandel & Kjelmand 2001; Turner & Margo 1998; Benson 2005). Participation in Balint groups, along with other professional and personal activities, has the potential to prevent compassion fatigue and burnout in participants (Benson 2005). They develop a more holistic style, a more constructive attitude to psychosomatic syndromes, and are less probable to refer patients or order redundant tests (Kjeldmand 1998). Balint groups were recommended as a long-term programme for correction of professional burnout in nurses, and the study proved useful in forming a positive professional culture (Savelyev 2017).

The Balint groups usually have from six to sixteen participants and one or two leaders. Meetings usually take place once or twice a month for several years. If the participants are from various disciplines, they can significantly enrich members by their differences (Botelho *et al.* 1990; Kjeldmand *et al.* 2004). The meeting begins with a presentation of the participant's case, in which he/she generally reflects the complicated interaction he had with the patient. The case is followed by a group discussion focusing on the ideas, emotions, and subjective responses that the presentation evokes (Lustig *et al.* 2006; Kjeldmand & Holmström 2008).

Usually, two cases are presented and discussed at one meeting. The group works for 90 minutes for one case. The Balint Group meeting aims is to stimulate a process like psychoanalytic "free associations" or "brainstorming". Participants are therefore invited to submit their cases without comment or medical record (Balint 1964). All group members are encouraged to share their ideas, fantasies, associations, imaginations, and emotions, not using direct advice or critique. This way of working makes it easier to create alternative views that can change the perspective of the problem and its solution.

In addition, members are free to talk about their unconscious attitudes towards the patient or the situation in a way that helps them to recognise their motives. Continued professional development and reflection in peer groups can help avoid burnout syndrome (Kjeldmand & Holmström 2008, Bar-Sela *et al.* 2012).

The application of the Balint group

The Balint groups are proposed to psychotherapists for enhanced supervision and increased effectiveness of their psychotherapy (Parker & Leggett 2014). Participants of the group bring cases and problems from their daily practice for the group assessment, analysis and elaboration. Unlike standard case reports or clinical case discussions, not only the patient's problem itself is subject to this examination, but also the relationship between the patient and the psychotherapist, the psychotherapist's motivation and emotional component, including various processes such as transference, counter-transference or projection, which affect treatment (Airagnes *et al.* 2014). The Balint groups can help with achieving main CBT supevision goals – the therapist can better understand their patient (conceptualization of the case), target his/her therapy more effectively (interventions), explore the therapeutic relationship and enhance self-reflection and also relationship within the group work adds experiential learning component. The Balint group focuses mainly on reflecting the more complex relationships between the helping person and the person being helped (Lipsitt 1999, Salinsky 2004). The whole process is designed to minimise the negative emotional burden associated with the case, and the therapist, through the views of other participants, has the opportunity to break away from their stereotypical thoughts and look at the situation from a new viewpoint (Turner & Malm 2004, Olds & Malone 2016).

In the group, participants discuss cases in the presence of one or two leaders trained in the method. They do not talk about technical or medical details but emphasize the story of the patient, the process of meeting them and the feelings evoked in the participants. Also provide safe, emphatic and collaborative working space. The Balint group strives for more contextual understanding of the therapy and it's problems and help to solve issues, provide support for the case presenter: the case conceptualization from different sources (fantasies of group members, self-reflection, indirect guided discovery), therapist-patient – others involved relationship, give ideas for treatment plan and intervention. The group work with unique features of limited reparenting atmosphere can have impact on members emotional status and more positive more in-depth experience. The Balint group aims to better understand the patient's story and broad circumstances, including the therapist-patient relationship for better assistance of the patient (Stelcer 2011, Van Roy *et al.* 2015). Another aim of the group discussion is to increase knowledge, learn how to think clinically and have the opportunity to reflect on their work in a safe environment. The dynamics of the Balint group have patterns described in the modern theory of small groups (Johnson *et al.* 2004, Kjeldmand 2006). This group dynamics can be both supportive but sometimes also hurtful or threatening and can be influenced by environmental conditions. For both collaboration and corrective emotional learning, the Balint group and its leaders can adopt limited reparenting concept from Schema therapy, which has features of both attachment (safety, empathy, acceptance, warm) and assertiveness (guiding, empathic confrontation, limit setting), features, and also meets core emotional needs of the case presenter and group members.

The Balint groups are considered beneficial not only for case supervision itself but also for the mental health of participants and continuous learning about the development and management of therapist-patient relationships (Kaplan *et al.* 1989). The subjectivity of therapists and doctors is an integral part of everyday work. By offering therapists a platform to present and discuss complicated interactions with patients, the Balint group can allow them to explore and express aspects of their subjectivity (Van Roy *et al.* 2014). The aim is not to leave with a definitive solution to the problem, but to thoroughly reflect on the problems from many perspectives. The process of self-reflection may lead to an eventual change of one's attitude, which will allow alleviating stereotypes and emotional burden. Research has shown a positive effect on participants' psychological well-being, job satisfaction, as well as the ability to enhance self-reflection and reflection in therapy (Balint *et al.* 1966; Kjeldmand *et al.* 2004; Kjeldmand & Holmström 2008; Turner & Malm 2004; Margalit *et al.* 2005). The Balint groups are officially recommended to promote reflection and well-being among general practitioners (Swedish Medical Association 2001).

Course of the group

A joint Balint group consists of 7–16 participants and one or two leaders (Parker & Leggett 2013). Occasionally, an even wider audience is used, sitting around the inner circle with active participants and watching without intervention – expressing their opinion at the very end of the discussion (Johnson *et al.* 2004, O'Neill *et al.* 2016). The Balint groups often meet repeatedly, for example, every week, sometimes for several years. Working in a group has a fixed structure with separate parts. It is based on an unchanging sequence of six usually 15-minutes blocks during which we deal with a specific problem is dealt with in the prescribed form (Johnson *et al.* 2004). One group lasts about an hour and a half. A free collaboration of the participants is essential – if they don't perceive the group as some place were to talk about their mistakes and present their professional flaws, it can become an unmanned theatre (Parker & Leggett 2012).

The Balint groups consists of subsequent steps::
(1) Case selection (selection from 3-4 cases)
(2) Case Exposure (situation and topics)
(3) Questions (completion, clarification)
(4) Fantasies (impressions, feelings, associations, intuitions, stories, characters)
(5) Practical recommendation
(6) Recapitulation by the case presenter (protagonist), what was important, and self-reflection and recapitulation by the participants.

The Balint group course (all phases) have many CBT supervision features: assessment, case conceptualization, interventions, exploration of the therapeutic relationship, reflection and experiential learning.

The basic principles of working in the Balint group is listening and reflection. In the Balint group, the supervisors create safe environment for the curious exploration of the case, where case presenter and members feel listened to, supported and understood, become more aware about they own feelings, along with triggered schemas and present modes, allow curiosity to emerge, and meet core emotional needs of the group (also indirectly patient's): a sense of safety and being securely attached to others, a sense of self-identity and autonomy, the freedom to express feelings and ask their needs from others, the ability to play and be spontaneous, safe, age-appropriate limits and boundaries. For this purpose, the rule of confidentiality is used as it is in other groups. Also, only one person speaks at a time; each participant speaks only for himself/herself, usually using no direct opinions but fantasies ("my fantasy that the client..., "if I would be the therapist…"), leaders less dominating. To create a safe environment, the leader discusses the rules with all participants, and they can add some more, e.g. "sticking to the topic", "being brief" and "respecting the opinions of others".

(1) Case selection

Case selection is the introductory phase of the Balint group. Those who sit in the inner circle are invited to present cases that bother them and would like to try to solve them with others (Van Roy *et al.* 2017, Player *et al.* 2018). The topic for discussion is usually chosen from 3–4 short case reports, which the participants briefly present in 2-minute descriptions. As a rule, they shortly present the case and what problem they experience in delivering therapy with this particular case.

Supervisor: Hi, welcome to the Balint Group. Think briefly and raise a hand, who has a story to discuss today?

The leader will offer the first candidate about 2 minutes to describe his/her patient, their relationship and the therapy itself to date, and the most important features. Then he/she asks for another offer. As a rule, the leader will invite members of the group to point toward a therapist whose story they would like to discuss in that group. Voting can take various forms, ranging from collecting papers with the names of candidates to each group member directly expressing, which topic attracts them most or to tell the candidate how much the topic is "hot" for him/her. After selecting the topic, the actual work begins. Then the supervisor prompts the selected therapist to tell the story of the patient, the therapy and the relationship.

Tab. 1. Main structural parts of the Balint group and CBT features

The phase of the Balint group	CBT features	Goals of the phase
Case selection: a selection from 3-4 cases	Finding and describing a problem, choosing main topics, reflection, exposure	Shortly introduce the case, select the main question, choose case by the group
Case exposure: protagonist story	Assessment, conceptualization, problem analysis, choosing main goals, behavioural exposure, reflection	Introduce to the case and problems in therapy, choose main topics, exposure to the group
Questions of the group	Assessment, **clarification, guided discovery**, conceptualization, insights, exposure	Gather and clarify information in a safe and emphatic way
Fantasies about the case and related topics	**Conceptualisation**, discovery, insights, "brainstorming" other views, reflection, feedback, exposure, emphatic confrontation, limited reparenting	Promote more contextual conceptualization, get feedback.
Practical recommendations – fantasies "what I would do in the therapist shoes".	**"Brainstorming" of interventions, problem-solving, treatment plan**, role model, guided discovery, exposure, emphatic confrontation and limited reparenting.	Promote strategy finding and problem-solving
Recapitulation – a reflection of 1) the protagonist 2) the group 3) group leader (optional)	Summarization, self – reflection and reflection, planning, choosing interventions, feedback, role modelling, limited reparenting, flexibility	Summarization, reflection, feedback

 ISSN 1337-933X (print), e-ISSN 1338-4015 (online)

(2) Case exposition

In the first part, the case presenter or protagonist (the one who brought the case) reports on the case. He tells the story of his patient for 15 minutes, in which he articulates everything about the patient, therapy, and the therapeutic relationships, what problems, difficulties or obstacles arise. It is not limited to facts but lists all the contexts that can bring the case closer to others and help to understand it (Samuel 1989; Rabinowitz *et al*. 1994; van Roy *et al.* 2014). The protagonist's feelings are an essential part. The protagonist (supervised) describes what happened, how was the course of the therapy, what problems, and what he/she needs from the group. The participants only listen.

Supervisor: Please tell us about this patient, his/her problems and your relationship. You have 15 minutes. Try to say everything that comes to your mind. I'll watch the time.

Protagonist: The patient is an unemployed woman at the age of 34. She cannot find any job, saying, "No one wants me; no one gives me a job." She often feels guilty that she can't get the job. On the other hand, she says she is fighting, trying to do her best. Her partner is offensive and often tells her unpleasant things. She says she's worthless, she's so stupid she can't even find a job. When the patient talks about relationships, she says, "Nobody loves me. I am alone in this world, and only my children love me". The patient's goal of the therapy was to find a job. Then the goal changed to her private life. She said she wanted to trust herself more and assert herself against her partner. In the next session, she talked about how aggressive her mother is, how her mother screams, criticizes her, never appreciates anything. At other times, she talks about bodily symptoms such as headaches, heart pressures, and palpitations and that she is afraid of being ill. At each session, she comes up with a new problem. She often changes the subject in one meeting. She does not do homework. I am angry with her because she often changes goals; she does not respect the timeframe (coming early or late, trying to get an extended session; she also came with the child repeatedly). I feel lost in therapy. I try to motivate her, but I don't know how to preoccupy her ... I did so many things, but nothing works .....

(3) Questions

Thorough presentation of the case, the other participants in the inner circle can ask for further details and clear up uncertainties to better understand what is happening in the situation. The group asks the protagonist about everything they would like to know about the patient's case, the patient's relationship with the therapist, and the therapy itself for 15 minutes. They ask about the circumstances and all the context they need to know in order to be able to create a picture of what happened in the patient and therapist (Kulenović & Blazeković-Milaković 2000). Participants are invited to ask questions with empathy, without judgement, and listen to answers without interruption.

Supervisor: Thank you. You told us a lot. Now, the group can spend 15 minutes asking the therapist for everything you would like to know about the patient, her life, relationships, therapeutic relationship, what is happening in therapy, and whatever you consider essential.

George: How many sessions did you have?

Protagonist: Eight.

Lena: What do you like about this patient?

Protagonist: She's smart and has a good sense of humor, and if she does her homework, she's okay. Unfortunately, she usually does not do so.

Petra: What is her early experience? Did you find out her schemas?

Protagonist: Her father died when she was four years old, and her mother remarried two years later, but her stepfather was emotionally abusive. She says she is unlovable, that no one can like her because she is terrible, defective. She also says she's incapable. Furthermore, she blames the others, for being evil and hurting her. The whole world is evil.

Jana: What is the most challenging thing about working with her?

Protagonist: Maybe I can't help her as quickly as I want. Also, she is usually late and does not do homework. I'd like to help her, but she's so erratic ... she keeps changing topics. I'm sorry, but I'm also angry with her. She flies into tempers, but so do I ...

The group's leader can encourage to ask questions which help to CBT case conceptualization – to recognise thoughts, feelings, body sensations, impulses to act or actual behavior, and memories underlying the therapist and the client relationship. Fritzsche and colleagues have suggested some examples of questions (Fritzsche *et al.* 2014):

- What do you think the client was feeling at that moment?
- What kind of person is the client?
- What feelings does this client elicit in you? How does the client shape his/her therapist to his/her needs and vice versa?
- Is there an underlying "disrupted fit" between the client and his/her environment and how is this reflected the therapist-client interaction?
- How do you think the client sees the therapist?
- What does he/she think of him/her?
- Why did the doctor behave as he/she did in this situation, and what did he/she want to achieve with this behavior?
- Is there something the patient is missing in his/her life? (Fritzsche *et al.* 2014)

(4) Fantasies

In the third 15-minute phase, the other participants communicate everything they think about in the form of their fantasies. This is the most productive phase of the whole process, the phase of fantasy. "All we hear is an opinion, "our fantasy", not fact, and all we see his point of view, not the truth," the leader /supervisor usually states. The participants try to empathise with the protagonist's experience and behavior, perceived events and people around him and recall similar events from their previous experience (Adams *et al.* 2006; van Roy *et*

al. 2017). Especially important understand that critique of the therapist and his work could reduce workgroup effectiveness because increase group members defensive reactions, that is why is so important to use safe talk and the history of therapy work use just like information which worked in therapy process or not.

Moreover, depending on this plan, other interventions help with generating fantasies, and all group members can safely find what examples they had in the past, and use this information to help the client. The group members have 15 minutes to fantasise about what was happening or going on with the patient and other characters in their story, what was going on with the therapist or therapeutic team. The fantasies are presented by the members, for example: "I have a fantasy about the patient, I have a fantasy of the patient's mother… I have a fantasy about the therapist… I have a fantasy of nurses working in the department…" The protagonist only listens. Group members will reimagine the parties and problems involved trying to describe what they are feeling. They talk about their feelings and fantasies that relate to the protagonist, the client or others who are mentioned in the case. The group leader should always remind that fantasies should not be an assessment of other procedures (e.g., the expression "I have a fantasy that the therapist did not make a good contract" is not recommended). Putting emphasis on fantasy is very important to diminish defence mechanisms of case presenter and group members. At this stage, the group is mainly interested in expanding the possibilities - it is similar to the rules of brainstorming (the aim is to think of as many ideas as possible, but the basic rule is not to evaluate). It is useful to encourage the participants to include fantasies that are unlikely or absurd. It is crucial for the whole phase that the participants begin their entries with the statement "I an imagery that…", "I imagine that…". This form emphasizes that these are purely our ideas, which helps in their acceptance and protects the protagonist (Samuel 1989). This phase is set again for 15 minutes.

The presenter tries to pay attention to their thoughts, feelings, body perceptions, and fantasies during the group`s reflection. There can be variations of emotional states and impulses to react. The presenter may feel angry, misunderstood, anxious, frustrated, sometimes even want to say something. Reactions can also be about how colleagues deal with the case, including relief, curiosity, anger, fear and confusion (Fritzsche *et al.* 2014).

Leader: Thank you, the questions were rich, and there could certainly be more, but the time for questions is over. The next part is your fantasies about what is happening to the patient, her partner, her parents, children, and the therapist. Fantasise about, how do you understand the patient's story, its relationships, problems and interrelations, the story of therapy, the relationship between the therapist and the patient, etc.
(in this part the protagonist only listens to the group). The leader emphasizes that these are fantasies, not reality.

Lenka: My fantasies are that the patient's initial experience was challenging. She soon lost her father soon, and then she had an offensive stepfather who, criticized and often beat her, so that her basic emotional needs of acceptance and love were not met. She also couldn't feel safe. That is why she created schema patterns with regards to being accepted and safe. Thus, she felt worthless, unloving, unlovable, and powerless. She has also developed a compensatory rule that every time she does something, she has to push herself to the limits to be accepted... Nevertheless, also, that she must defend and fight for others to accept her. This is because of her diligence and the conflicts she has with her husband and mother, but also at work, so she was repeatedly fired.

George: I have the imagery that the client tries to be perfect, but the therapist also tries to be perfect. Because it is an overclaim and cannot be fulfilled, both of them are angry. The client is angry with her husband and children. Also, with her mother, who reminds her that she is not perfect and thus, she does not feel loved. She then tries to "move" her husband in some way, especially with remorse, in order to show her love more, but he is already exhausted from the remorse, so he escapes more and more to work, which makes her even angrier and then she explodes at the children. Also, in therapy, her perfectionism prevents her from engaging in a therapeutic action plan due to unconscious wish to either do things right or do not do them at all. She also fears that the therapist will criticise her as a mother that she did not do well. Therefore, it often brings nothing, and the therapist criticizes her as a mother. The therapist also tries to be perfect, she wants to help the client, but on the other hand, the client disrupts her efforts for perfection by often not having homework, changing the themes all the time. She presents such a quandary for the therapist.

Vlasta: I have fantasies about counter-transference… the therapist feels similarly incompetent and unkind as the client, and so she tries to push the client even more, which is the overcompensation mode. Then it becomes a challenging task for the therapist to disengage from these feelings of inadequacy and see what is happening. It resonates with me as I often find myself in similar situations not being able to see what is happening… I also have the imagination that changing topics, criticising the client, and lack of homework triggers the Vulnerable Child in the therapist when she feels helpless and then gets into the Angry Child with the client. She is controlled, but I have the imagery that the client feels the anger and repeats her experiences with her mother.

Peter: My fantasies are that both feel they are a therapeutic relationship. At the same time, they have a good relationship with each other because they feel they are similar in something and both want to solve a similar problem - feel accepted and try to do it with the help of the over-compensator - do everything perfectly, or with the Avoidant Protector - avoid talking and saying some things that would prove unkind or helpless….

Supervisor: I have the imagery that the therapist feels empathic towards the client and has a human need to help her, and I also have the imagery that she has already helped the client a lot … and that the client perceives the therapist as a "good mother". I also have the imagination that the therapist would like to be a good mother, and she is angry with herself for being occasionally

angry with a client for being late or not following the action plan. However, I have the imagery that the relationship is excellent; that is why the client has been attending the sessions for so long, it satisfies her basic needs.

(5) The fantasy about what I would be doing in the role of a therapist

In the fourth step, the 15-minute phase group show what others would do in place of the protagonists. This is the stage of group brainstorming. The goal is to have fantasies about how to proceed. Even at this stage, participants are encouraged to get as free as possible from the assessment of the situation. At the beginning of this phase, the group leader reminds that it is not just about formula, but also about empathy for the protagonist. The traditional introductory wording is "I have the imagery that if I were a therapist, I would ...". The participants offer practical procedures of their choice (not advice). If the ideas are too general, it is useful as a facilitator to support specific messages. At this fifteen-minute stage, participants offer their views and solutions (as they would have done), but do not give advice, blame or evaluate the protagonist (Horder 2001).

Supervisor: Thank you, the time for this part is over. Now let's move on. In the next 15 minutes of fantasies. I invite you to imagine what could I do if I was a therapist?

Jitka: If I were a therapist, I would think about both the client's emotional needs and my needs. Furthermore, I would start working with the dysfunctional thought that she is unkind. I would be looking for how this pattern of kindness throughout her life from three years old, to the present.

Martin: I have the imagery that if I were a therapist, I would do the imagery rescripting. Especially those negative experiences with mother, analyzing situations from childhood to present. I would work on the emotional bridge.

Petr: I have the fantasy that if I were a therapist, I would mainly discuss how she feels in therapy with me and whether she sometimes has the same feelings with me as she has with her mother or husband. I would be interested in its transference because I think it can block our work ...

Lena: If I were a therapist, I would have the imagery that I would mainly explore her experiences of childhood and puberty. I think there are a lot of aversive experiences, and I wonder what she experienced in them, how she experienced them, and what she is experiencing similarly nowadays. Yes, I would try to create that emotional bridge to help her understand the connection between what she experienced in childhood and what she is experiencing today.

(6) Evaluation - benefits

In the fifth and final phase, the protagonist who brought the case to the group comes to the floor and comments on the suggestions and observations of colleagues. The protagonist talks about what they were interested in how they experienced the group. The protagonist appreciates the new perspectives and the experiences, and express how their expectations, which they formulated at the beginning, have been met. The protagonist chooses from the heard material and names the solutions that most appealed to them. A group reflection follows this, and individual participants evaluate the benefits for themselves that they take away from the group. Then each participant says what they are taking away from the Balint Group for themselves and their clients.

Supervisor: Thank you all for your rich fantasies. Now I'll get back to you Zuzka. What was important to you during the group? The protagonist says what was essential to her in this Balint group.

Protagonist: For me, it was crucial to realize that I have some similar features with my patient. I also need acceptance, and I try very hard to be perfect because I think I will be accepted then. We have this in common, though she worries about it a lot more. I realized I was angry with her because I couldn't be perfect, but also that I had a good relationship with her and wanted to help her. I also realized that I was afraid to start rescripting the difficult childhood situations with her because I was afraid of her emotional repercussions. However, it is my avoidance rather than hers, and I am afraid that her violent emotions would then explode and she would leave hurt. But I have done it so many times, and I should go for it.

After the whole phases are completed, it is useful to take a short break. It is worth noting to the participants that they may still want to give the protagonist some ideas or recommendations after the group is over. It is natural, but at the same time, it is recommended not to do so and let the protagonist calm down and absorb the whole process of the group.

Role of the group leader

The selection of supervisory group leaders is important. They are supposed to be able to lead the discussion, to take and give the space to talk and keep the boundaries of the prescribed phases of the Balint Group also their task is to provide a clear structure of work. From the Schema therapy concept, the group leader should be in Healthy Adult mode "a good enough" parent of the group: genuine, emphatic, accepting, non-judgmental, validating also guiding, leading when needed. The group leader must be someone who knows this form of discussion (Torppa *et al.* 2008; Lipsitt 1999; Johnson *et al.* 2004; Flatten *et al.* 2019). They need to create a secure environment in which participants can look at a particularly problematic situation with a patient from a new perspective (Kjeldmand *et al.* 2004; Stelcer 2011; Yakeley *et al.* 2011). The leader monitors each step of the process, introduces them to the group, and engages in discussions only when needed. A requirement is an impartiality, the ability to protect participants, create an atmosphere of security, demonstrate acceptance and appreciation, can retreat into the background and not

promote their own opinions (Kulenović & Blazeković-Milaković 2000).

Specific leadership behaviours include protecting the protagonist from interrogation-type questions, encouraging the group's open fantasies, avoiding premature solutions, and helping to tolerate silence and uncertainty. Although the Balint group leaders can rely on dynamics to evolve similarly to other small groups, they need to create room for a different purpose than in psychotherapeutic groups - the goal is not the group member but the patient.

The leadership of the Balint Group may be led with different styles (Merenstein & Chillag 1999), but in any case, the main aim is to create a safe environment for creative reflection on the doctor-patient relationship, while protecting the referring physician (Balint 1964; Johnson *et al.* 2004; Kjeldmand & Holmström 2008). In the introduction, the group leader will introduce or remind the groups of the rules and conduct the process (the structure helps to maintain the involvement of participants and allows protection for mutual learning) and states its role. The leader watches over the rules during the group session and monitors the timeframe, indicating the phases. During their work, the leader should be attentive and focused in order to capture a possible protagonist's assessment on time and at the same time to gently intervene if the process does not adhere to a sufficiently secure way (Graham *et al.* 2009). The leader can also invite the other participants to shared facilitation, i.e. to help the Balint Group process through their input. Sometimes a leader could add his or her fantasies in the fourth and fifth step only if something essential is missed. The decision to add fantasy should be accurately deliberated – will it benefit the protagonist and will it enrich the group process. It could be done only in the last minutes of the fourth and fifth step not to interrupt group members' fantasies process. Leader's involvement depends on Balint's group member professional level – if almost everyone is on novices' position, leader's involvement is possible, but if group members are more professionally experienced, leader's involvement in fantasies process is unnecessary.

The leader must guard the discussion so that the protagonist is not compromised, as maintaining therapeutic relationship matters for an affective work. Respect for who brought the problem is essential. The leader makes sure that the protagonist leaves without being upset. This should give them a better understanding of the problems, awareness of transference and counter-transference, and an idea of what to do next (Dahlgren *et al.* 2000; Graham *et al.* 2009). In the end, the leader thanks for their courage.

Although effective management is considered essential to good Balint practice, there is insufficient research to assess the importance of the group leader's personality in the Balint Group's results, let alone the impact on patients. Tschuschke & Flatten (2019) sought to identify the influence of the group leader on the "typical processes" in the Balint groups. 1460 physicians from 352 Balint groups in Germany, Austria, and Switzerland were involved in the study. Participants rated 80 Balint's leaders in three dimensions. However, they were not able to ascertain the influence of individual dimensions of the group management on its process.

Benefits and disadvantages of the balint group in the cbt supervision

The main advantage of the Balint Group in CBT supervision is the high level of safety of the participants who support each other. The Balint group promotes creativity, the ability to look at problems from many perspectives and levels and teaches how to hierarchize and select the most clinically relevant ideas and consider their implementation in practice. In the group discussion, the supervisee ´s goal is to create a comprehensive conceptualization of the case and link it to therapeutic strategies. The significant advantages are group work and mutual enrichment of group members, and joint development of complex clinical view. The group also understands what is going wrong and encourages its members to accept their own mistakes because they all made them. This universality works similarly to a psychotherapeutic group. Another important factor is mutual learning from each other. The protagonists bring cases of patients that are similar to those of other participants, so the entire group learns on each case how to think and cope with their patients' problems. If the group is well managed, it can effectively confront the participant's mistakes in fantasies, who then do not feel criticized for not doing something they should or missing something. The participants learn to separate the error from the personality of the protagonist whom they learn to respect. This has a retroactive impact on others who realize that if they made a mistake, it does not mean that they failed as humans or therapists. If the protagonist does not receive support from the group, it is appropriate to be supported by the group leader.

The disadvantage of the Balint group is that they provide little opportunity to concentrate on the details of the therapist's work, and there is little opportunity for experimental learning through role-playing or imagery. The phases are arranged logically sequentially, but their system does not allow to go back to questions in the imagination stage, although at this stage, new questions may arise in the mind of the participants. For security reasons, the Balint group does not allow controversy between different views, which may deprive the participants of ideas that arise from polemics.

Problems which may be faced when managing the balint group

The Balint group may not always benefit all members. Kjeldmand & Holmström (2010) analyzed problems in the Balint groups. The analysis identified three categories of difficulties:

(1) the vulnerability, defence and needs of individual therapists;
(2) people (including leaders) who have problems with covert requirements, rivalry and frameworks;
(3) an environment defining group conditions.

Too critical in fantasies

The group can be critically focused on questions and fantasies and hurt the protagonist. Emerging groups tend to seek errors, not alternative views and practices. With the maturity of the group, the ability to communicate things with empathy, curiosity about the opinions of others, even if they are opposite and the ability to respect them increases. One of the group leader's tasks is to protect the protagonist from being hurt by the group. Usually, this is done by expressing empathy for their feelings or reflecting on how the leader himself would feel in the role of the protagonist.

Change hurts

Sometimes the new understanding is unwelcome or too shocking to be internalised (Kaplan *et al.* 1989; Arrow *et al.* 2000; Holmström & Rosenqvist 2004). Discussions can evoke memories or feelings from the members' own lives that are too painful to be compatible with continuing within the group. This risk is higher in group members who feel fragile, experience mental health struggles or some turbulence in their own lives..

Too much pressure on the protagonist

The group may also exert excessive pressure on the protagonist. It can easily happen that members of the group begin to say what the protagonist should do, how they should behave, etc. It is an essential task for the group leader is to manage the work of the group so that everyone tells their fantasies about what they would do not as a therapist, but always advise the protagonist as a part of a team looking for a way to solve the situation.

Scapegoat

Girard describes the scapegoat theories as fundamental phenomena of human group behavior (Girard 1986; Jensen 1991). In groups, rivalry or conflict between members can evolve into united aggression against one member. Rivalry among all, in general, evolves into stable chaos in a group where all are united against one, a scapegoat that has an opinion or handicap that others are unable to empathise with. The scapegoat is excluded from the group. The excluded member embodies the group's aggression, and the group feels relaxed and comfortable after this ritual. The scapegoat may be an ordinary member, but most often, a person who has some unique attributes, gender, race, a personality that dissolve as soon as they are recognized and named. Some of the Balint group members who fall out may be therapists or doctors whose particular need for gentle guidance and protection has been ignored. Besides, the group leaders themselves can succumb to the group's influence and support the exclusion of a member. The fixed boundaries of the Balint group should help prevent this phenomenon from appearing, but the boundaries may fall when hidden agenda appears in the group.

The participants of the group argue with each other

The participants of the group can have different opinions, which they express in fantasies and tend to say, for example, "Francis is not right, I think that ...". The leader must emphasise that fantasies are always inherent and there should not be a controversy between each others´ fantasies, but what an individual thinks of the problem themselves or how they would solve the problem should be expressed. Everyone has the right to their own opinion and imagination.

Too general, no fantasies

Some members of the group use vague, unspecific, unspecific fantasies, such as "I have a fantasy that the therapist has countertransference to the patient"! or "I have the imagery that the patient did not have the basic emotional needs fulfilled!" It is the task of the group leader to ask at this point, "Can you make this more specific?"

Extremely dominant member

An overly dominant member sets the mainline of imagination and others tend to follow it without considering their perspective. For example, they tell the client has a diagnosis here and there, and that is what they need to do, and if someone dares to say something else, they argue again for what they said before. The group leader must come in with the importance that what we say is nothing more and nothing less than imagination because we do not know and have not evaluated the patient, so we cannot speak of any truth. It is essential to respect all the fantasies that emerge.

The hegemony of the Balint leader

An overly dominant or over-compensating Balint leader may wish to show less experienced group members how capable psychotherapist he/she is, how well he means, how well he sees beneath the surface, and so on. It may appear in the content and in the way how the group is being led. For example, it could present as a tendency to tell his or her fantasies during the process. However, also, it could appear in non-verbal communication: actively nodding to ideas he or she liked or rolling eyes when disagreeing. This efficiently suppresses the work of the group members, who will then await expert advice and are not encouraged to develop their clinical judgment.

They may also be afraid to say anything because they have the impression that they still know little. The task of the group leader is to support the independence of the group members, not to instruct them.

Group surrenders before the solution or labels the patient
The group feel sorry for the patient and does not offer a solution, or is convinced that the patient is too difficult, not motivated, and cannot be helped anyway. This surrendering before the solution affirms nihilism and deprives the group of creativity. Because the group has a significant influence on the protagonist, the surrender of the group or the labelling of the patient removes the therapist's hope in both treatment options and motivation to engage the patient further. It is crucial that the group leader streamlines the process and expresses fantasies that increase the chances of treatment options and remove patient labelling.

Out-of-group contacts of the group leader and individual participants
Contacts between the leader and members outside the Balint groups are not considered beneficial.

Double roles
How the group is established has a significant influence on its development of the group and the way it handles its tasks. Balint's work in compulsory groups could, therefore, be different from voluntary groups. According to Arrow *et al.* (2000), the primary problem for members of the so-called "mixed groups", which are overviewed by external management, is how to meet external requirements. These are groups that are in the workplace where superiors and subordinates are present, and the ability to behave openly and confidently contrasts with the position and power of superiors. The situation is quite different in groups that arose outside formal structures that are initiated and planned by internal forces, as voluntary groups where members coordinate and integrate their own goals, intentions and expectations. Some group leaders according to the study by Arrow *et al.* (2000) reported problems with truancy, resistance, and inertia in compulsory groups, reflecting the feeling that leadership and disciplinary power sit in the room. This inevitably affects group work because Balint´s work depends on trust and openness.

On the other hand, if the environment is negative for the Balint group, the group leader may be obliged to penalise members for the activity as a natural part of the training of young doctors. They then might have difficulty escaping from the requirements of clinical departments in the group work. Therefore, there should be no superiors and subordinates in the Balint group, as all members come to the meeting to solve their problems and say how what they are failing in and secondly, superiors tend to advise and recommend (Graham *et al.* 2009).

Conclusion

The method of supervision or intervention within the Balint Group is particularly useful in dealing with problematic therapies, conflict situations between therapists and patients, or problem situations in the therapist's team. With a secure environment and a tightly limited and managed process, experiences, concerns and failures can be shared with other participants without fear. Participants may gain unexpected insight and understanding of their own emotions while empathizing with the challenging situation the protagonists experiencing. From our experience, the Balint groups have many features of CBT area supervision and can be a valuable part of the learning process. Participants mostly like this kind of work.

Professionally led Balint groups seem to be a gentle and effective method for supervising and educating therapists, psychologists and physicians. Member participation requires psychological stability and an open mind. The ability of clinical thinking, the flexibility of opinions, the ability to engage in dialogue and to accept and discuss the opinions of others are developed via group work. Professionally led Balint groups to seem to have a positive impact on patients and the therapist's personal growth.

Conflict of interest statement

The authors declare that the article was written in the nonappearance of any commercial or economic relationships that could be understood as a potential conflict of interest. For the last two years, Dr Julius Burkauskas has been serving as a consultant for Cogstate, Ltd.

Acknowledgments

This paper was supported by the research grant VEGA no. APVV-15-0502 Psychological, psychophysiological and anthropometric correlates of cardiovascular diseases.

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