


Balint in the time of COVID-19: Participant and facilitator experience of virtual Balint groups compared with in-person

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Abstract

Background: Current literature highlights peer and psychological support as important for staff well-being, to cope in pandemic conditions.

Aims: Our organisation increased Balint group provision during unfamiliar challenges of COVID-19. This unique context allowed comparison of multiple new virtual and face-to-face (F2F) Balint experiences.

Method: Following March 2020 lockdown, four existing Balint groups for doctors in psychiatry moved to online, with two new groups established virtually in specific response to the pandemic. All participants and facilitators of these virtual Balint groups were sent a questionnaire to anonymously rate their experience and provide qualitative feedback.

Results: The response rate was 89% for participants (51 respondents) and 100% for facilitators (5 respondents). Participants found both formats supportive; providing a space to talk, feel heard and validated, helping work feel less stressful. Participant ratings slightly favoured F2F, but some prefer to continue virtually. Facilitators felt virtual attendance was easier, but adherence to conventional Balint group structure and format more difficult.

Conclusions: Participant and facilitator responses demonstrate Balint groups, when both F2F and virtual, were experienced as a source of support and connectivity, being

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valued across different psychiatry grades. Notable virtual benefits seem to be limited to more practical aspects, that is, time, flexibility, logistics and accessibility. There are expressed challenges of virtual Balint; however, some participants still favour this format going forward. Our findings endorse virtual Balint as a welcomed means of emotional well-being, peer support and developing psychotherapeutic competencies during pandemic-related restrictions, with potential to extend beyond COVID-19.

Keywords

COVID-19, Balint, pandemic, well-being, psychiatry, psychotherapy, training, peer support

Article summary

Strengths of this study

- This study evaluates new online Balint groups as an intervention to bolster staff peer support and well-being, whilst continuing to meet psychotherapy training needs. This unique context allows parallel evaluation of participant and facilitator perspectives, comparing Balint group experiences in virtual format during the pandemic with those face-to-face (F2F) before COVID-19. This extends previous research with comparatively greater participant sample size, in addition simultaneous measurement and comparison amongst different medical seniorities.
- Survey responses generated a vast depth of qualitative data

Limitations of this study

- Respondents retrospectively rated F2F experience after attending virtual Balint groups, thus may be subject to recall bias. Respondents were asked in February 2021 to rate virtual Balint between March to August 2020.
- Potential confounders arise from ratings of the two formats being made during very different contexts: normal working conditions (when F2F Balint group is the norm) and pandemic conditions (when F2F is not available). This is partly due to study design but also the extraordinary circumstances of COVID-19. To improve validity, context would be controlled however it wasn't possible at the time of this study, exposing to recall bias. An additional consideration is that the 6 different Balint cohorts varied in regularity of groups (more senior grades being less frequent).
- Almost two thirds of respondents were female which may not be an accurate representation of the overall trainee gender mix.
- Perceptions of virtual Balint may be skewed by recency bias. Having Balint, irrespective of format, could make participants grateful to have any peer group at all during COVID-19. Conversely, participants might consider virtual as a half-

measure in extra-ordinary circumstances, and therefore idealise the original F2F format, which was lost and not an option at that time.

Introduction

As clinical practice and training evolve, the emphasis on communication skills and emotional awareness has found increasingly greater importance from both patient and clinician experience. In the 1950s, Balint groups were first taking root via family physicians, that is, general practitioners, and since have progressively extended worldwide to include students, trainees and qualified staff in varying professional disciplines.¹ Balint groups have become a mandatory part of core psychiatry training, in accordance with The Royal College of Psychiatry competency requirements.²

Prior to COVID-19, there appeared to be an increasing need and desire for reflective groups such as Balint to provide a professional space to support the psychological impact of difficult clinical interactions and situations. Increasingly a number of countries have reported on the use of Balint groups in overcoming professional isolation, loneliness and burnout.³⁻⁵ According to the British Medical Association, this need was noticeably heightened since the pandemic.⁶ Balint, having started as a necessary adaptation to fit the 'psychosocial turn' of postwar Britain,⁷ may again be particularly relevant to the front-line (a term once attributed to the battlefield)⁸ NHS worker. The psychological impact of infectious disease outbreaks on healthcare workers has been recognised, with high rates of both acute and chronic mental health illness in professionals caring for the infirm.^{9,10} When considering the psychological consequences of exposure to trauma, the literature suggests a lack of post-trauma social support and exposure to stressors during the recovery from trauma, as strong predictors of mental health status.¹¹ Empirical evidence stresses the need to address detrimental effects of outbreaks given the known psychological toll on staff, in particular front-line clinicians.¹²

Peer support and focus on emotional well-being have been highlighted as important for healthcare workers to cope and persevere in relentless pandemic conditions; however, there is limited evidence-base evaluating how these are actually delivered.^{13,14} Research has noted that effective peer support can best occur between participants who consider themselves as equal. such as being at a similar career stage and discipline, to remove the common hierarchical influences in medicine.¹⁵ Due to COVID-19 infection control restrictions, efforts have started to assess the role of telephone and video in supporting clinicians.¹⁶ A pilot study explored Balint groups via virtual technology.¹⁷ A randomized controlled trial of Balint groups for preventing burnout among residents in China included 18 participants in the intervention arm and reported groups to be helpful, with over 80% satisfaction and interest in attending further, however, findings did not reach statistical significance.¹⁸

A nursing study, again in China concluded a short-term Balint group can improve the communication ability and self-efficacy level of front-line nurses to some degree.¹⁹ Another study, in Iran, evaluated online Balint groups for healthcare workers caring for

COVID-19 patients, finding statistically significant and favourable use of Balint, albeit in a small study of only 10 participants.²⁰

In the UK, similar studies are in earlier stages of research, for example, have introducing weekly Balint into an intensive care unit for medical staff, presenting a reflective report but with no quantifiable outcomes at present.²¹ Reflections have been published on facilitating Balint group remotely with positive qualitative responses; however, no participants had prior experience of Balint in any capacity.²² A Balint support group offered to medical staff of all seniorities has been described which formed COVID-19 well-being support for staff as part of a qualitative study planned for a later date.²³

The impact of the COVID-19 has raised concerns around well-being as the pandemic progressed, particularly for training doctors. An Australian study had found levels of psychosocial distress were up to 12 times higher in doctors under the age of 30 years compared with age-matched individuals in other professions.²⁴ During unfamiliar challenges in this time, Birmingham and Solihull Mental Health Foundation Trust (BSMHFT) increased Balint group provision for psychiatry doctors to provide support, helping them explore the emotional impact of clinical practice and difficult interactions. Balint interventions were delivered in groups reflecting doctors' level of training and experience, being mindful of the hierarchical structure of medicine which research suggests influences the dynamics.

In summary, there is an increasing body of Balint research suggesting benefits to well-being and professional advantages, though there is a relative lack of empirical evidence for Balint group effect for qualified staff,^{25,26} with a comparatively larger body of research studying impact on students or trainees. This could be influenced by funding and budget restraints, difficulty recruiting facilitators²⁷ and possibly less priority on reflective groups after qualifying. Most of the data is collected from small sample sizes and there is paucity of studying Balint group effect in specific situations, at times of crisis or in virtual format. Additionally, the authors are not aware of any work investigating grade-specific groups of trainees and qualified staff concurrently, or comparing different formats of delivery.

Our study evaluated the new virtual format as an intervention to bolster staff peer support and well-being, and continue to meet psychotherapy training needs.²⁸ This unique context allowed parallel evaluation of participant and facilitator perspectives, comparing Balint group experiences in virtual format during the pandemic with face-to-face (F2F) pre-pandemic. This extended previous research with a comparatively greater number of group participants, in addition to the simultaneous measurement and comparison amongst different medical seniorities.

Method

Doctors working for BSMHFT during 2020 attended Balint groups in their respective cohorts that is, core training (CT) years 1–3, higher training (ST) years 4–8, middle grade SAS (staff-grade, associate specialist, specialty doctors) and consultants. After the first COVID-19 UK lockdown in March 2020, existing CT1 (13 members), CT2 (8 members), ST4-8 (17 members) and consultant (4 members) Balint groups moved to an

online format via Microsoft Teams. New CT3 (9 members) and SAS (6 members) groups were established virtually in specific response to the pandemic. The frequency of groups varied from weekly for CT1s, fortnightly for CT2, CT3, STs and SAS, and monthly for consultants – frequency of already established groups matched that of previous F2F. CT1 and CT2 groups continued mandatory attendance as part of training, with the four other groups as optional but strongly encouraged during the pandemic. Decisions around frequency and attendance reflected a perceived greater Balint need for most junior trainees compared with more experienced clinicians. It was left to participants and facilitators' discretion and personal needs whether they attend virtual Balint at their workplace or from home, with many required to do similar in their clinical practise.

Facilitators were predominantly medical psychotherapists; however, none with previous virtual Balint experience. Due to a conflict of interest between overseeing the entire Balint programme and evaluating this study, one facilitator was excluded, leaving a total of 5 remaining. Despite this facilitator being excluded, every group facilitation-experience was represented in this study as some groups were co-facilitated pairing junior (CT/ST) with more experienced senior staff (consultants).

All 57 participants that attended any of these virtual Balint groups, and the 5 facilitators, were sent a questionnaire via Survey Monkey. This was sent out in February 2021, with electronic reminders over a 2-week period. The majority of participants had prior experience of Balint-type groups and so were also asked to retrospectively rate virtual Balint (March-August 2020) and previous F2F Balint group experience (suggesting an equivalent 6-month time period September 2019–February 2020).

Participants and facilitators were required to rate their experience of 14 and 12 statements, respectively (see [Tables 1](#) and [2](#)). These statements were based on existing Trust Balint feedback questionnaires (taking into consideration The Royal College of Psychiatrists expected psychotherapy competencies),² and edited to incorporate virtual and COVID-19 related factors from literature review of the related evidence-base available. Both participant and facilitator surveys included a mandatory question about respondent's perceived gains and losses of virtual Balint (results were analysed thematically), and two optional questions encouraging additional unstructured qualitative feedback.

Results

The response rate was 89% for participants (51 respondents) and 100% for facilitators (5 respondents).

Respondents answered all rating questions. Weighted averages were calculated to draw comparisons as seen in [Tables 1](#) and [2](#). In the final part of the survey, all participants and facilitators were asked 'What are your perceived gains and losses of moving from face-to-face to remote Balint groups?', with optional free-text space for the final two questions: 'My suggestions for future Balint groups are...' and 'Any other comments about your Balint group experience...'

Table 1. Participant reflection data, responses on a five-point Likert scale (1 = strongly agree, 5 = strongly disagree).

My Experience of Balint Group has....	Virtual	Face-to-Face
	Mean	Mean
Deepened my understanding of difficult patient-clinician interactions	1.78	1.55
Provided an opportunity to explore challenging emotional aspects of clinical work	1.69	1.49
Helped me reflect and increase awareness of my own feelings and limitations	1.71	1.56
Helped my understanding and awareness of transference and counter-transference	1.80	1.63
Provided a space for me to talk and feel heard	1.92	1.66
Helped me feel validated by and more confident around peers	1.94	1.80
Felt a safe space to share confidential and difficult material	1.82	1.66
Made me feel more supported	1.86	1.78
Made me feel tired and/or drained afterwards	3.39	3.49
Helped work feel less stressful	2.55	2.41
Felt a good group size	2.10	1.90
Felt appropriately facilitated	1.73	1.71
Been easy to attend and fit into other commitments	1.92	1.90
Made me more likely to attend future Balint groups	1.86	1.85

Table 2. Facilitator reflection data, responses on a five-point Likert scale (1 = strongly agree, 5 = strongly disagree).

	Virtual	Face-to-Face
	Mean	Mean
The group was successful in reflecting on difficult patient-doctor interactions	1.60	1.50
There were rich discussions in the group	1.60	1.25
There was appropriate focus on transference and countertransference phenomena	1.60	1.25
There was active and balanced group engagement	2.20	1.25
Participants adhered to the expected Balint group etiquette and boundaries	2.20	1.75
The group felt safe and contained	2.20	1.50
It was easy to keep to timings and boundaries	2.20	1.75
Group size felt appropriate	2.20	2.50
The group made me feel tired and/or drained afterwards	2.20	2.75
I enjoyed facilitating	2.00	1.50
It's been easy to attend and fit into other commitments	1.00	2.50
This experience has made me more likely to facilitate future Balint groups	2.00	1.75

Participants

63% of participants identified with a female gender, 37% male and none as ‘other’. Training levels were distributed as in [Figure 1](#).

Participant qualitative data

When asked about perceived gains moving to virtual Balint, qualitative analysis revealed the following participant themes with their respective codes bracketed: *convenience* (ease and flexibility of attendance, improved attendance, comfort of working from home and travel time gained); *emotional comfort* (feeling welcomed and supported, less threatening and anxiety inducing); and *connecting during COVID-19* (feeling supported, staying connected).

When asked about perceived losses moving to virtual Balint, qualitative analysis revealed the following participant themes with their respective codes bracketed: *communication* (difficulties accessing non-verbal information, disruption to natural flow of group and inhibited expressions); *intrapersonal connections* (increased distractions, challenges to being fully present and more passive engagement); *interpersonal bonds* (reduced peer support, less authentic interactions and less meaningful connections); *safety* (worries about cyber security, threats to privacy and confidentiality); *technology* (IT connectivity and device dysfunction); and *group processes* (blurred boundaries and diminished psychodynamics).

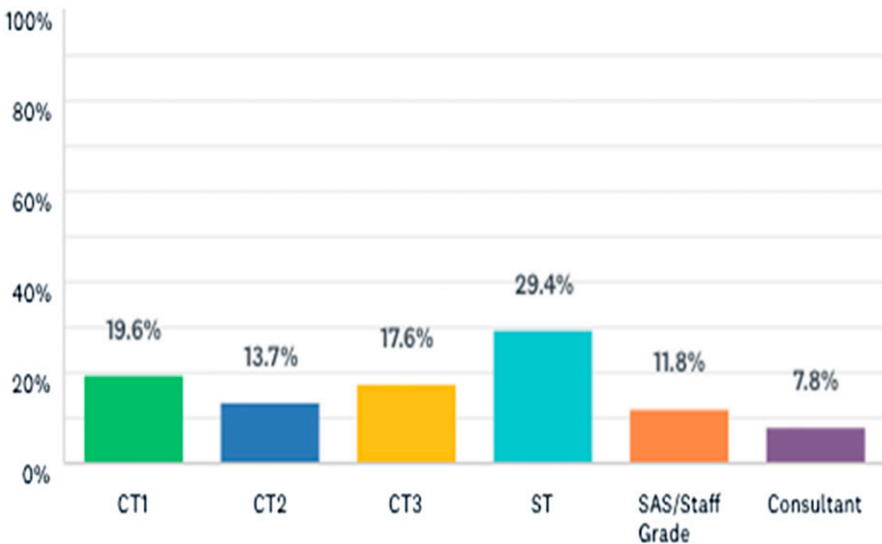


Figure 1. Participant training level (Mar–Aug 2020).

Participants commented on their future format preferences as per [Table 3](#). These were unstructured free-text responses to being asked to comment on their suggestions for future Balint groups. When reviewing the data, participants were categorised as favouring a ‘mixed format’ when they requested an option of both virtual and F2F be given for participants to choose from. Participant suggestions for future Balint groups included ‘smaller groups’; ‘more frequent groups’; ‘more regular timings.’; wanting ‘more structure online’; more clear rules & adherence to boundaries eg time/repetition of content for latecomers; ‘raising hand’/using remote App function on Teams; ‘keeping video on’; more content/explicit theory eg ethics and interest in attendance to meet ‘ARCP competency’.

When asked about anything additional they wish to share regarding participant experience, 35.3% of all respondents commented, with 27.4% of participants submitting positive feedback including ‘appreciate reflective space’; gratitude to felt value around ‘going online quickly’; gaining ‘insight into psychological processes’ and Balint ‘added to training experience’.

Facilitator qualitative data

When asked about perceived gains moving to virtual Balint, qualitative analysis revealed the following facilitator themes with their respective codes bracketed: *convenience* (no travel time, ease of attendance and improved attendance); and *time* (easier to manage). Thematic analysis revealed the following facilitator themes for perceived losses in moving to virtual Balint: *technology* (IT connectivity, device dysfunction and competing IT demands); *interactions and processes* (reduced engagement, weaker group interactions, loss of dynamic processes, less natural flow and harder to access non-verbal information); *boundaries* (harder to maintain and manage effectively); and *effort* (more demanding and tiresome).

Facilitators commented on their future format preferences as per [Table 4](#). One facilitator was categorised as favouring a ‘mixed format’ as they requested both F2F and virtual options being afforded to participants to promote flexibility. Another facilitator suggested once Balint groups are ‘established’ F2F, they could in future consider transition to virtual format to promote greater attendance. When asked about

Table 3. Participant preference on future Balint format.

Participant preferences	Tally	%
Continue virtually	14	27.5
Prefer F2F	9	17.6
Indifferent	8	15.7
Mixed format	2	3.9
Didn't comment	18	35.3
Total =	51	100.0

anything additional they wish to share regarding facilitator experience, two comments were made: '*Remote groups might be appropriate as an adjunct for some qualified staff (i.e. not trainees) who could not otherwise access a Balint group e.g. due to geography*' and '*Answers depend on group and level of ease of members with method*'.

Discussion

The impact of a pandemic on clinicians threatens exceptional psychosocial distress thus raising the need for additional support. There is increasing international evidence of the supportive benefits of Balint group participation with work-related stress and well-being, suggesting grouping peers into respective cohorts as favourable.¹⁵ This study's overall findings support and extend the growing body of research in this field.

Of the 51 study participants, average ratings suggest slight preference of F2F (with the exception of rating feeling tired/drained post-Balint), and overall experience when conducted virtually was rated approvingly. This was particularly for non-CT groups where geographical challenges (e.g. region-wide ST Balint) or competing clinical demands (e.g. consultant/SAS Balint) made regular commitment and attendance more difficult when F2F. Participants rated both formats as supportive, helped work feel less stressful and were a space to talk, feel heard and validated.

Of the 5 Balint group facilitators, average ratings suggest stronger preference of F2F (with the exception of rating ease of attendance and fitting into other commitments). Facilitators interestingly rated feeling more tired and/or drained when F2F, despite this being their typical mode of Balint delivery. As crude speculation, perhaps commuting and thus greater overall time taken when F2F is reflected in this rating.

Participant themes suggest the transition to virtual Balint groups during COVID-19 was welcomed and valued, enabling colleagues to feel '*connected and supported during this difficult time*'. The gains of virtual Balint groups, for participants and facilitators, were closely connected to the practical aspects of this mode of delivery, the ease of attendance and time-saved. Both participants and facilitators felt virtual format increased the accessibility of the group and improved attendance, with one facilitator noticing members attending that hadn't previously. Several participants shared finding virtual Balint less anxiety-provoking, particularly with larger or more unfamiliar

Table 4. Facilitator preference on future Balint format.

Facilitator preferences	Tally	%
Continue virtually	-	-
Prefer F2F	4	80.0
Indifferent	-	-
Mixed format	1	20.0
Didn't comment	-	-
Total =	5	100.0

groups. These participants experienced virtual Balint as a less threatening and more inviting experience, *'I have been more expressive since virtual Balint'*. Facilitators shared finding it easier to manage the timings of the group when it was delivered virtually.

Participant and facilitator themes identified a range of perceived losses, particularly when comparing with F2F Balint groups. There was a felt sense of loss with regards to communication, particularly non-verbal information and cues. Participants found it *'harder to read the group'*, and both participants and facilitators described the virtual experience as *'artificial'* and *'less natural'*. Participants *'found it difficult to judge appropriate moments to contribute'*, making it *'harder to interact'* and for some this resulted in them inhibiting their communications and expressions.

Loss of connection was a theme that emerged particularly clearly from the data, in relation to intrapersonal and interpersonal experiences. Participants commented on how the *'lost human contact'* before, during and after the session, resulted in a more disconnected group experience with reduced feelings of peer support. When compared with face-to-face Balint, participants shared a reduction in the quality of these interpersonal experiences with some suggesting doubts about the authenticity of the interactions. This seemed to contribute to a sense of there being less meaningful connections between the group members and this was *'really missed'*. The feeling was echoed in intrapersonal experiences, with participants and facilitators sharing that a virtual format invited more distractions in the form of competing attentional demands. Participants shared more personal challenges to being fully present and a sense that virtual delivery enabled a more passive engagement. Facilitators also noticed reduced engagement with some participants speaking little or not at all, which could be explained by perceived weaker group member interactions – perhaps the virtual format promotes isolative feelings as opposed to the shared human contact of physically sitting next to each other when F2F.

In terms of effort needed, one facilitator shared the virtual experience as *'much more demanding/tiring'*, however, averaged facilitator ratings contrasted this. Technological difficulties, such as device dysfunction and interrupted internet connectivity, appeared to further compound and were felt by both participants and facilitator. One factor not accounted for is group size. In particular the higher trainee (ST) psychiatry doctor group as it forms the largest cohort; contributing to almost 30% of overall participant feedback. This group's size when virtual was more than double that when F2F, which is likely to have influenced their individual experience and overall study findings.

Losses in communication and connection were closely linked to a theme of threat; feeling less safe and less secure online. Some participants shared challenges in maintaining a private and *'confidential space'* when working from home, with worries of being *'over-heard'* and fears around *'cyber-security'*. This is a concern restricted to virtual Balint, and although some facilitators explicitly addressed issues around confidentiality when starting virtual Balint group, in reality this cannot be guaranteed or enforced remotely and so comes down to trust and individual responsibility.

In terms of process, several facilitators shared that virtual format made maintaining Balint group frame and boundaries more difficult, with participants also noticing some blurring of boundaries. Regarding psychodynamic-specific concepts, a few participants commented they were *'less able to feel transference during presentation and discussion'* with facilitators echoing *'loss of subtle transference and countertransference dynamics occurring in group'* when virtual.

This pilot study has limitations and there are likely multiple complex confounders at play. The most significant confounder is that ratings of the two formats are being made about two very different contexts: normal working conditions (when F2F Balint group is the norm) and pandemic conditions (when F2F is not available). This limitation is in part due the study design but also due to extra-ordinary circumstances of COVID-19. Perceptions of virtual Balint may be skewed due to recency bias and perhaps because participants are grateful to have any group at all during COVID-19. Conversely, participants might consider virtual as a half-measure in extra-ordinary circumstances, and therefore idealise the original F2F format, which was lost and not an option at that time.

All respondents were asked to retrospectively rate their F2F experience after having had virtual Balint groups, therefore introducing further bias. Ideally an initial survey would have been sent out (prior to starting virtual Balint) to only those that had previous F2F experience. This could allow a paired sample of direct comparisons and potentially lend itself to more in-depth quantitative analysis. Respondents were asked in February 2021 to rate virtual Balint between March and August 2020. Average ratings were weighted collectively, whereas it could have been more valuable for them to reflect and be representative of the different psychiatric grades and groups sizes, that is, senior and more experienced (SAS and consultant) Balint groups had significantly less participants. An additional consideration is that the 6 different Balint cohorts varied in regularity of groups (more senior grades being less frequent). Almost two-thirds of respondents were female which may not be an accurate representation of the actual trainee gender mix.

Key findings

Participant and facilitator responses demonstrate that Balint-type groups, when both F2F and virtual, were experienced as an important source of support and connectivity, feeling professionally and clinically beneficial across different psychiatry grades. Our findings indicate that virtual Balint continued to promote clinician well-being during COVID-19 pandemic-related restrictions.

Notable benefits of virtual Balint seem to be limited to more practical aspects, such as time, flexibility, logistics and accessibility. There are expressed challenges of virtual Balint to communication, connection, group processes and security. Despite this, ratings of overall experience and dynamics support both formats. This invites exploration and study into the overall meaningfulness of Balint groups, in general, for psychiatry doctors.

Our findings suggest that the convenience, accessibility and time-saved through a virtual group format is highly valued by psychiatrists of all grades, despite compromises to the Balint group process. Our study validates virtual Balint as a welcomed means of emotional well-being, peer support and developing psychotherapeutic competencies during the pandemic. This has potential to extend to other disciplines and beyond COVID-19. Future research may explore any adaptations to these virtual groups that are necessary to maintain the integrity of Balint.

Contributorship

Dr Sheliza Samnani has authorship for design, project analysis, interpretation of data, drafting, revising and final report. Dr Masud Awal, in his role as psychotherapy tutor and lead for this pandemic Balint initiative, holds responsibility for planning and executing this project, as well as the overall content as editor and guarantor. His contribution as co-facilitator to one of the six Balint groups, and thereby exclusion from survey sample, is detailed in Method section.

Declaration of conflicting interests

The author(s) declared no additional potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

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Patient and Public Involvement

Although clinicians may share cases pertaining to patient encounters and experiences, this adheres to UK General Medical Council (GMC) Good Medical Practice confidentiality and clinical governance. There was no direct public involvement, aside from, by proxy sharing of content around patient's personal history and life, again in confidential professional group settings as per GMC.

Disclosures

I confirm, in writing and submitting there is no conflict of interest, ethics nor funding declaration required. A full abstract has been published on BJPsych Open; 7(S1): S154-S155, 2021 as part of acceptance of a poster to the The Royal College of Psychiatrists International Congress 2021. This full report and findings, however, have not been submitted elsewhere nor published before. Full data and thematic analysis are available by emailing sheliza.samnani@nhs.net.

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