Iran J Psychiatry Behav Sci. 2021 June; 15(2):e107962. doi: 10.5812/ijpbs.107962.

Published online 2021 June 7. **Research Article**

Front-Line Medical Staff Experience About the Novel Psychological Intervention of Brief and Online Balint Group: A Qualitative Study in Iran During the COVID-19 Outbreak

Fatemeh Sheikhmoonesi [1,*], Maryam Rezapour [1], Mohammad Azizpour [2] and Ideh Ghafour [1]

[1] Psychiatry and Behavioral Sciences Research Center, Addiction Institute, Mazandaran University of Medical Sciences, Sari, Iran
[2] Islamic Azad University of Tehran, Teran, Iran

[*] *Corresponding author*: Psychiatry and Behavioral Sciences Research Center, Addiction Institute, Mazandaran University of Medical Sciences, Sari, Iran. Email: fmoonesi@yahoo.ca

Received 2020 July 28; **Revised** 2021 February 18; **Accepted** 2021 February 20.

Abstract

Background: During coronavirus (COVID-19) pandemic, frontline medical staff were exposed to numerous psychological problems due to unpredictable conditions. A psychological intervention for medical staff is the provision of a group where emotions and feelings are shared.
Objectives: The purpose of this study was to evaluate the experiences of front-line medical staff about virtual Balint group.
Methods: Eight sessions of virtual Balint group were held through Skype. Participants were the frontline medical staff involved in the treatment of COVID-19 patients. The group leader was a psychiatrist and an analytical psychotherapist. The group had two co-leaders, a clinical psychologist and a psychiatrist. They were both experienced conductors who had a background of participation in Balint groups. Finally, eight in-depth semi-structured interviews were performed. Interpretative phenomenological analysis (IPA) was carried out to analyze the obtained data.
Results: Three themes were extracted, including the effects of Balint group, Balint group structure, and virtuality of Balint group. Each theme included several categories, and each category had some codes.
Conclusions: Leaders in the Balint group were active and had a supportive role. Some participants did not share their faces, and this made others feel insecure. Body language is an important issue in empathy and understanding of others that is overlooked in virtual Balint groups.

Keywords: COVID-19, Internet-Based Intervention, Medical Staff, Qualitative Research

1. Background

During the coronavirus (COVID-19) pandemic, frontline medical staff are susceptible to the risk of viral infection as well as numerous psychological problems due to unpredictable conditions, excessive work pressure, extreme fatigue, exposure to critically unwell patients, high mortality of patients, dearth of means for protection against the virus transmission and concerns regarding the virus transmission to family members (1-3). On account of confrontation with very difficult conditions, some might suffer from moral injury in decision-making, like when they are supposed to take care of critically-ill patients with insufficient or confined resources.

Moral injury could give rise to negative thoughts about oneself or others, resulting in intense feelings of embarrassment, guilt, and disgust, the symptoms which might end in mental disorders such as depression, post-traumatic stress disorder, and even suicidal thoughts (4, 5). Different clinical groups engaged in attending to very ill patients, who impose mental and emotional burdens on therapists, are usually subject to occupational burnout, an issue which might possibly impact physician-patient relations (6, 7). Prior research indicated that close relation with COVID-19 patients and direct engagement in their physic-mental traumas expose frontline nurses to traumatization. Accordingly, further attention should be paid to the psychological problems of this group (1, 8, 9).

Crises could enhance tolerance and resilience, and the degree to which a patient suffers from post-traumatic stress disorder or is favored by post-traumatic growth is contingent upon the support they have received before and during their trauma (10). Previous studies have suggested teletherapy for patients, their families, and medical staff under quarantine conditions (11). During the COVID-

19 epidemic, a limited number of studies have been carried using psychological interventions for medical staff. In a Chinese research, online and hotline training courses were held for medical staff in order for them to deal with common psychological problems (3).

A psychological intervention for medical staff is the provision of a group experience where emotions and feelings are shared, bringing about a drastic change in viewpoints on physician-patient relations. Participation in Balint group (7, 12, 13) can improve mental health and increase tolerance in clinicians and decrease occupational burnout (14-16). However, during the COVID-19 outbreak, Balint groups are not arranged to prevent virus transmission.

2. Objectives

This study was aimed at arranging Balint groups in a new way in cyberspace and examining participants' experience.

3. Methods

This was a qualitative study with a phenomenological approach that was conducted in Iran in April 2020.

3.1. Participants

Participants were recruited via message invitations on WhatsApp. The researchers introduced Balint group briefly in virtual groups related to medical staff and suggested that every frontline medical staff requires to join the Balint group. Medical staffs were recommended to take part in Balint groups if they needed mental support. The inclusion criteria were frontline medical staff involved in the treatment of COVID-19 (including physicians, nurses, and anesthesia experts) and consent to participate in Balint group. Twenty-one individuals volunteered to take part in the Balint group, who were contacted by the group leader to arrange an interview and provide them with detailed descriptions. The participants were asked to install Skype software, which was done by 13 volunteers who could then enroll in the Balint group.

3.2. Balint Group in Cyberspace

Virtual Balint sessions were held twice a week for four weeks (totally eight sessions) in a closed group. In this virtual Balint group, the presenter sat back by turning off his/her microphone, and other members did not address him/her for 25 minutes and talked to each other about their thought association. The group leader was a psychiatrist and analytical psychotherapist. Due to the great pressure of the pandemic in the Balint groups, we decided to run the Balint group with two co-leaders: one a clinical psychologist and the other a psychiatrist. The leader and co-leader were experienced conductors who had a background of participation in Balint groups. The leader and co-leader were responsible for maintaining structure in the group and directing dialogues so as to prevent the derailment of the argument and concentrate on the physician-patient relationship.

3.3. Interviewer

At the end of the Balint sessions, the members who provided consent were interviewed by a psychiatrist in order to record their experiences on participation in the virtual Balint group. The interviewer was a psychiatrist who had adequate familiarity with the Balint group. To make it easier for the participants to comment and express their opinions, a psychiatrist other than the leader and co-leader interviewed them.

3.4. Data Gathering

In individual interviews, which is a common method to collect data in qualitative studies, viewpoints, incentives, and experiences of participants are explored. Thirty to forty-minute in-depth semi-structured interviews were held through telephone due to epidemic conditions. After introducing themselves and expressing their intentions, the interviewer asked the interviewees to record their talks. The interview started with this open-ended question: "What was your personal experience regarding the virtual Balint group?"

With respect to the expressions made by interviewees, deepening and developing questions were asked. They were then asked: "What was interesting for you in the virtual Balint group?", "Did you feel enough security to freely share your thoughts and emotions with others?", "How could the Balint sessions impact the way you perceive physician-patient relations?", and "How could the Balint sessions impact your negative emotions about patients, workplace, or yourself?"

3.5. Data Analysis

All individual interviews were recorded, typed, and analyzed by MAXQDA-2020. The primary source of data was the interview. Interpretative phenomenological analysis (IPA) was carried out due to the inclusion of a qualitative analysis of a phenomenon on the basis of the experiences reported by the interviewees.

First, all the collected data was read to obtain a degree of immersion and sense of the whole. The data was read accurately to extract codes by spotlighting the text's exact words, which seemed to stand for pivotal concepts

and views. Analysis proceeded by coding interviewees' expressions and classifying them by two skilled psychiatrists, who were supposed to read them a couple of times to categorize codes, themes, and categories. After eight interviews, data saturation was reached, and no new code was added.

3.6. Rigor

To evaluate the accuracy, the researchers used the credibility, dependability, confirmability, and transferability criteria (17). To obtain data credibility, the participants undertook a member-checking process. To determine the confirmability of the data, peer checking was performed by the researchers. For dependability, an independent observer familiar with Balint group was consulted. To establish transferability and in accordance with maximum variation sampling, the participants were from different fields of medicine.

3.7. Ethical Considerations

The participants voluntarily enrolled in this study, and their informed consent was obtained. They were told that they could interrupt the interview procedure whenever they wished, and, in case it was found demanding by them, they could withdraw from the study. Individual interviews were recorded only after participants' consent was obtained. This research was approved by the Ethics Committee of Mazandaran University of Medical Sciences and Health Services under the code of ethics IR.MAZUMS.REC.1399.7662.

4. Results

Table 1 indicates characteristics of the participants.

After the data obtained from individual interviews were analyzed, three themes were extracted, including effects of Balint group, the structure of Balint group, and virtuality of Balint group. Each theme included several categories, and each category had some codes (Table 2).

4.1. Effects of Balint Group

This theme alludes to the impacts of the Balint group on the participants, and it has three categories.

4.1.1. Relationship with a COVID-19 Patient

This study was conducted under the conditions of the COVID-19 pandemic, and its participants were all engaged in the treatment of these patients. On this account, most patients enrolled in the Balint group suffered from COVID-19. The participants largely concentrated on their relationship with these special patients, talking about their emotions regarding these patients. "Early after the spread of coronavirus", P3 uttered, "I feared encountering patients with COVID-19. I was anxious that I might get sick too. After a short while, I grew furious with these patients, who, I thought, had disregarded social distancing protocols and hygienic regulations. I was angry that they might infect me, as well". Another participant said: "I was scared of patients with COVID-19 in the beginning. After participation in Balint sessions, however, I could better control myself. I talked to patients. I could empathize with them" (P2).

4.1.2. Education

Participation in Balint sessions is a type of learning. P1 stated: "The experience of participating in a Balint group was like that of taking part in a peer supervision training session". And that: "Group will learn how to proceed. The first session might not be good; however, it will get better from the second and third sessions onward" (P1).

4.1.3. Therapists' Feelings

Impact on the therapists' own emotions was one of the most significant effects of Balint group as held by the participants. Some therapists were anxious and considered this anxiety to be a shame for them. When a patient talked about his/her emotions of fear and anxiety to the participants, it was a good opportunity to hear others' emotions in the event that they were exposed to such patients. This could help validate their emotions. P7 stated: "When I visited a patient, I was curious to know whether or not others bear similar emotions". Common emotions among participants helped them feel that they were not alone. P2 said: "The most important contribution of the Balint group to me was that I knew that other therapists have similar fears and anxieties". All the participants expressed that their unpleasant emotions, such as anxiety, fear, and guilt caused by helplessness against patients, were diminished following participation in the Balint group. "Hospital was nightmarish in the beginning", P2 continued, "I felt that we are all supposed to die. Later, however, this feeling was decreased".

4.2. Structure of Balint Group

Another important theme, which was obtained through interviews with Balint participants, was the structure of the group.

4.2.1. The First Session

Since most participants referred to the difference between the first session and the subsequent ones, we allocated an independent code to the first session. Although all the participants were interviewed and instructed about the purposes and structure of Balint group prior to the first session, some participants experienced discomfort in the

Table 1. The Demographic Characteristics of the Participants in the Virtual Balint Group

Participant	Age	Sex	Marital Status	Occupation
P1	31	Female	Married	Psychiatric resident
P2	30	Female	Single	Nurse Anesthetist
P3	44	Female	Married	General Physician
P4	26	Female	Married	Medical student
P5	25	Female	Married	Medical student
P6	57	Female	Married	Nurse
P7	34	Female	Single	Psychiatric resident
P8	24	Female	Single	Medical student

first session. P7 said: "I was under pressure myself; I was anxious and sad. I didn't want to talk about patients with COVID-19 as if I wanted to ignore them". P2 expressed: "In the first session, it was hard for me to talk for fear of being judged". Insecurity was reported in the first session.

4.2.2. Leaders

Two participants had the experience of taking part in face-to-face Balint groups. "In these sessions", P1 uttered, "leaders were more active. They freely expressed their opinions as if they were a member of the group. It was a good experience for me. I didn't continue the previous Balint group as its leaders were too taciturn." P3 said: "Leaders protected me; they didn't permit others to judge me".

4.2.3. Heterogeneous Group

Most participants reported that the interaction in a group whose participants were in different academic levels was greatly established. In Iran, the medical hierarchy is very important. A medical student, P5 stated: "I thought that this is a hierarchy-based group where medical students are not permitted to talk. This was not the case, albeit. The group had a friendly atmosphere".

4.3. Virtuality of Balint Group

The innovation of this study was its virtual arrangement. This theme had three categories:

4.3.1. Face of Participants

In this group, showing or revealing face was not indicated as a rule. Some participants had clear faces, some displayed fixed profile images, and others had neither face nor profile images. The two codes of 'seeing' and 'being seen' were assigned to participants' opinions. Most of them preferred to see others' faces, believing that emotions would be better appreciated if their faces are observable. P8 indicated: "Establishment of eye contact, especially when talking, can improve a relationship". However, P8 neither showed her face nor uploaded an image of herself. On the other hand, some participants were uneasy to reveal their faces, considering the absence of the requirement to show their faces as a strength of the virtual Balint group. "Before the first session", P2 uttered, "I was anxious about the necessity to show my face. Later on, however, I found out that one might choose to hide his/her face. This improved my conditions". When P2 was asked: "What is difficult in showing your face?" she replied: "I was fearful of being judged".

4.3.2. Positive Points

Except for the first session, where participants had feelings of insecurity due to their unfamiliarity with Balint structure and other participants, all the participants in our virtual Balint session experienced feelings of security. "Respecting security", P1 commented, "I didn't care about virtual or classical Balint groups". During the COVID-19 epidemic, we had no other choice. The participants were also content that they were able to easily take part in sessions from their home or workplace. P3 indicated: "I was happy that I could participate in the session from my room with a closed door. I didn't need to travel to the place where the session was arranged". The participants had taken part in Balint groups from different cities. P1 believed that: "Arrangement of virtual sessions gave me the sense of traveling beyond the borders, the sense that there is no confinement".

4.3.3. Obstacles

In virtual Balint groups, only faces were viewable. Yet, some preferred not to show their faces. Body language could not contribute to conveying emotions. "In one of the sessions", P4 remarked, "I kept quiet until the end of the session, and no one reacted to me! In a face-to-face session, however, other participants will certainly find out one's silence. And, this adds to their mutual sympathy". Another obstacle to take part in a virtual Balint session was the inability to use Skype. P6, who was older than the other par-

Table 2. Themes, Categories, and Codes Related to Participants' Experience in the Virtual Balint Group

Themes and Categories	Codes	Meaning Units
Effects of Balint group		
Relationship with a patient with COVID-19	Decrease of fear from patients	Before Balint groups, I was fearful of patients with COVID-19. I was considering what happens if I get infected. I grew spunkier later on (P2).
	Decrease of anger from patients	I am not angry with patients with COVID-19 any longer (P4).
	Higher sympathy levels	In these sessions, I managed to see things through patients' eyes. This made it easier for me to accept their behaviors (P5).
	Clarity of different aspects of physicians-patients relationship	In session, patients are observed from different points of view (P4).
Education	Self-awareness	After participating in Balint sessions, I learned how to talk to my colleagues instead of brawling (P2).
Therapists' feelings	Validation of emotions	In groups, emotions were validated (P5).
	Not being alone	In groups, I found out that different participants are experiencing emotions like those of mine. This was very helpful (P3).
	Decreased unpleasant feelings (sadness, guilt, and anxiety)	Hospital was nightmarish in the beginning. It was like we are all supposed to die. Later this feeling was decreased(P2).
Structure of Balint group		
The first session	Being discomforted	In the first session, I felt that I don't like the group. I was unfamiliar with group's structure (P2).
	Insecurity	I feared that I might be later reproached by hospital officials for discussing hospital problems in a group (P6).
Leaders	Being active	Leader and co-leader were active in this group (P1).
	Supporting and not judging	Leader protected me and did not permit others to judge me (P3).
Heterogeneous group	Good interaction	I never thought that such a good interaction might be formed in a group composed of participants of different ages and various academic levels (P5).
	Absence of hierarchy	I thought that this is a hierarchy-based group where medical students are not permitted to talk. This was not the case, albeit (P5).
Virtuality of Balint group		
Positive points	Sense of traveling beyond borders	Arrangement of virtual sessions gave me the sense of traveling beyond the borders, the sense that there is no confinement (P1).
	Absence of the need for traveling	I was able to take part in the group from my room (P2).
	Security	The virtual Balint group was secure for me. There was no difference between a virtual and face-to-face Balint group (P1).
Obstacles	Unskillfulness and weak internet connections	Sometimes, I didn't know how to join the group. Either, it was hard for me to ask a question and say something (P6). During sessions, my internet kept dropping, and it deranged me (P8).
	Hiddenness of emotions	In one of the sessions, I kept quiet until the end of the session, and no one reacted to me! In a face-to-face session, however, other participants will certainly find out one's silence. And, this adds to their mutual sympathy (P4).
Faces	Seeing	I preferred that all participants reveal their faces. I was more comfortable this way (P5). Establishment of eye contact, especially when talking, can improve a relationship (P8).
	Being seen	If I was forced to reveal my face, I was fearful of being judged (P2).

ticipants, said: "Sometimes, I didn't know how to join the group. Also, it was hard for me to ask a question and say something". Using Skype required relatively high-speed internet. P8 commented: "During the sessions, my internet kept disconnecting, and it deranged me".

5. Discussion

Balint group has been recently introduced to the Iranian medical society and, thus, limited research has been conducted on this issue. On the other hand, COVID-19 pandemic-caused arrangement of Balint sessions in the virtual space is unique. In this qualitative study, participants expressed their experiences on the Balint group and its virtual arrangement. Even though the virtual arrangement of Balint sessions helped clinicians take part from different cities, taste the sense of traveling beyond borders, and evade geographical constraints, it came with its own problems. A prerequisite for participation in a Balint session was possession of a smartphone with an Internet con-

nection. Those clinicians who were deprived of this facility were not nominated for Balint participation. On account of the sanctions levied on Iran and inaccessibility to other resources, the best application for the arrangement of a Balint group was Skype, which required possession of a relatively high-speed Internet connection. Some participants had low-speed connections, which made them leave the session. For the same reason, some could not show their faces (although some participants preferred to hide their faces on purpose).

The two codes 'seeing' and 'being seen', were associated with deeper psychoanalytical issues. In his book, seeing and being seen, John Steiner addresses this issue (18). At an abstract level, being seen means coming into view of one's vulnerabilities and could lead to shame and humiliation. Some participants were overwhelmed by the sense of being judged and anxious when they were supposed to be seen even at a concrete level. For them, invisibility was a factor that could let them take part in sessions more comfortably and be psychologically supported by the peer group.

Balint sessions were planned under these critical conditions to provide clinicians psychological support, and it was not intended to address their internal conflicts. To avoid noises, the participants turned on their microphones only when they wished to give a speech. For this, some participants, who had an experience of taking part in face-to-face Balint sessions, expressed that it was harder for them to give feedback in a virtual Balint session.

When this research was performed, there were few studies about the online Balint group. Kiani Dehkordi et al. (19) designed a study to evaluate the impact of online Balint groups on healthcare workers caring for COVID-19 patients. According to that study, The average scores obtained from the Corona Disease Anxiety scale (CDAS) and Connor-Davidson Resilience scale (CD-RISC) were significantly changed after participating in eight sessions of the online Balint group.

In a face-to-face Balint session, leaders make attempts to maintain group's framework so as to prevent derailment of the argument and concentrate on physician-patient relationship. In this way, leaders opt for silence and prevent making active participation (20). In this study, the participants were clinicians and therapists who were under drastic psychological pressures and needed to validate their emotions through others' emotional support. In these virtual Balint sessions, the leaders played more active roles in directing sessions; this difference constituted the strength of virtual sessions compared to classic Balint sessions.

A study on the experiences of psychiatric residents in Balint groups has been carried out in Iran (16). In that study, one of the categories obtained from the analysis of data was 'at the beginning', which referred to the emotions which rose in individuals at the beginning of a Balint session. The findings of that study were largely in line with our results, especially regarding the three codes of anxiousness, confusion, and curiosity.

In our study, participants bore emotions of anxiousness and distress in their first session. Being unfamiliar with the structure of the session, they expressed that they were discomforted. Balint was a new phenomenon for many individuals, and they did not know what was exactly supposed to happen. The leaders, thus, played a major role in the initial Balint sessions in that they provided support for the participants who were overwhelmed by the emotions of insecurity and discomfort. We used a supportive technique in this modified Balint group because all the participants were under high pressure. Maybe, for this reason, some participants noticed the difference in leading style between this group and previous Balint groups.

Under critical conditions, applying the virtual space for a Balint arrangement could be beneficial. Virtual and modified methods could be used for the conditions where a classical and face-to-face Balint group cannot be held due to epidemic conditions and/or busy work schedules.

5.1. Limitations

A limitation of this study was that all the participants were female, whose experiences out of the expression of their emotions in a group might be different from those of male ones. Most of the participants were young and were acquainted with the virtual space and working with different applications.

5.2. Conclusions

Medical staff considered participating in the Balint group as a form of learning. The shared emotions among the participants made them not feel alone and considered their emotions valid. According to the participants who had participated in both face-to-face and virtual Balint groups, leaders in classical Balint groups were more active and had a more supportive role. Some participants did not share their faces, and this made others feel insecure. Body language is an important issue in empathy and understanding of others that was overlooked in the virtual Balint group.

Acknowledgments

We express our gratitude to Dr. Raymond Peter Brown, who was the supervisor of the Balint leaders, and his spouse, Ms. Shahabi, who was the language and culture translator.

Footnotes

Authors' Contribution: FSM and MR conceived and designed the study. MR and FDM analyzed and interpreted the results. FSM drafted the manuscript. FSM was the leader. MA and MR were co-leaders. IG interviewed the participants. All the authors read and approved the final manuscript.

Conflict of Interests: There is no conflict of interest.

Ethical Approval: This research was approved by the Ethical Committee of Mazandaran University of Medical Sciences and Health Services under the ethical code "IR.MAZUMS.REC.1399.7662".

Funding/Support: This study was supported by Mazandaran University of Medical Sciences.

Informed Consent: Participants made voluntary entrance into the study when their informed consent was obtained.

References

1. Li Z, Ge J, Yang M, Feng J, Qiao M, Jiang R, et al. Vicarious traumatization in the general public, members, and non-members of medical teams aiding in COVID-19 control. *Brain Behav Immun*. 2020;**88**:916–9. doi: 10.1016/j.bbi.2020.03.007. [PubMed: 32169498]. [PubMed Central: PMC7102670].
2. Brooks S, Amlot R, Rubin GJ, Greenberg N. Psychological resilience and post-traumatic growth in disaster-exposed organisations: overview of the literature. *BMJ Mil Health*. 2020;**166**(1):52–6. doi: 10.1136/jramc-2017-000876. [PubMed: 29420257].
3. Kang L, Li Y, Hu S, Chen M, Yang C, Yang BX, et al. The mental health of medical workers in Wuhan, China dealing with the 2019 novel coronavirus. *Lancet Psychiatry*. 2020;**7**(3). e14. doi: 10.1016/S2215-0366(20)30047-X. [PubMed: 32035030]. [PubMed Central: PMC7129673].
4. Greenberg N, Docherty M, Gnanapragasam S, Wessely S. Managing mental health challenges faced by healthcare workers during covid-19 pandemic. *BMJ*. 2020;**368**:m1211. doi: 10.1136/bmj.m1211. [PubMed: 32217624].
5. Williamson V, Stevelink SAM, Greenberg N. Occupational moral injury and mental health: systematic review and meta-analysis. *Br J Psychiatry*. 2018;**212**(6):339–46. doi: 10.1192/bjp.2018.55. [PubMed: 29786495].
6. Fothergill A, Edwards D, Burnard P. Stress, burnout, coping and stress management in psychiatrists: findings from a systematic review. *Int J Soc Psychiatry*. 2004;**50**(1):54–65. doi: 10.1177/0020764004040953. [PubMed: 15143847].
7. Benson J, Magraith K. Compassion fatigue and burnout: the role of Balint groups. *Aust Fam Physician*. 2005;**34**(6):497–8. [PubMed: 15931410].
8. Huang JZ, Han MF, Luo TD, Ren AK, Zhou XP. [Mental health survey of medical staff in a tertiary infectious disease hospital for COVID-19]. *Zhonghua Lao Dong Wei Sheng Zhi Ye Bing Za Zhi*. 2020;**38**(3):192–5. Chinese. doi: 10.3760/cma.j.cn121094-20200219-00063. [PubMed: 32131151].
9. Nickell LA, Crighton EJ, Tracy CS, Al-Enazy H, Bolaji Y, Hanjrah S, et al. Psychosocial effects of SARS on hospital staff: survey of a large tertiary care institution. *CMAJ*. 2004;**170**(5):793–8. doi: 10.1503/cmaj.1031077. [PubMed: 14993174]. [PubMed Central: PMC343853].
10. Mathieu F. Occupational hazards: compassion fatigue, vicarious trauma and burnout. *Can Nurse*. 2014;**110**(5):12–3. [PubMed: 25076569].
11. Zarghami M. Psychiatric Aspects of Coronavirus (2019-nCoV) Infection. *Iran J Psychiatry Behav Sci*. 2020;**14**(1). doi: 10.5812/ijpbs.102957.
12. McKensey A, Sullivan L. Balint groups - helping trainee psychiatrists make even better use of themselves. *Australas Psychiatry*. 2016;**24**(1):84–7. doi: 10.1177/1039856215598870. [PubMed: 26253524].
13. Graham S, Gask L, Swift G, Evans M. Balint-style case discussion groups in psychiatric training: an evaluation. *Acad Psychiatry*. 2009;**33**(3):198–203. doi: 10.1176/appi.ap.33.3.198. [PubMed: 19574515].
14. Roberts M. Balint groups: a tool for personal and professional resilience. *Can Fam Physician*. 2012;**58**(3):245–7. [PubMed: 22423015]. [PubMed Central: PMC3303639].
15. Aboujaoude E, Salame W, Naim L. Telemental health: A status update. *World Psychiatry*. 2015;**14**(2):223–30. doi: 10.1002/wps.20218. [PubMed: 26043340]. [PubMed Central: PMC4471979].
16. Yahyavi ST, Amini M, Sheikhmoonesi F. Psychiatric residents' experience about Balint groups: A qualitative study using phenomenological approach in Iran. *J Adv Med Educ Prof*. 2020;**8**(3):134–9. doi: 10.30476/jamp.2020.85161.1164. [PubMed: 32802907]. [PubMed Central: PMC7395201].
17. Lincoln YS, Guba EG, Pilotta JJ. Naturalistic inquiry. *Int J Intercult Relat*. 1985;**9**(4):438–9. doi: 10.1016/0147-1767(85)90062-8.
18. Steiner J. *Seeing and being seen, emerging from a psychic retreat*. London: Routledge; 2011. doi: 10.4324/9780203806364.
19. Kiani Dehkordi M, Sakhi S, Gholamzad S, Azizpour M, Shahini N. Online Balint groups in healthcare workers caring for the COVID-19 patients in Iran. *Psychiatry Res*. 2020;**290**:113034. doi: 10.1016/j.psychres.2020.113034. [PubMed: 32450413]. [PubMed Central: PMC7214277 interest].
20. Otten H. *The Theory and Practice of Balint Group Work*. London: Routledge; 2017. doi: 10.4324/9781315147055.