PSYCHOTERAPIA 3 (194) 2020
pages: 59–68
DOI: 10.12740/PT/127021

Bertrand Janota[1], Paulina Michalska[2]

BALINT GROUP IN THE PHYSICIAN-PATIENT RELATIONSHIP — ASSUMPTIONS, OBJECTIVES AND SIGNIFICANCE

[1]Klinik für Psychiatrie, Psychotherapie und Psychosomatik,
Carl–Thiem–Klinikum, Cottbus, Germany
[2]Department of Psychology, Kazimierz Wielki University, Bydgoszcz, Poland

"A physician is like a medicine and, therefore, their work must be tested for all expected activities and side effects" [1].

Balint group
doctor–patient relationship
mutual trust

Summary

During the intensive development of telemedicine, *i.e.* distance medicine, it is necessary to rethink the importance of the relationship between a physician and his/her patient. This relationship is the basis for effective therapeutic contact and the quality of communication plays a significant role at every stage of the treatment process. The cooperation between a physician and their patient is an interaction based on mutual trust, in which both the persons are involved independent of various determinants, *e.g.* related to their personality or life experiences. This raises the question of how a physician – responsible for the relationship with his/her patient – is able to provide conditions for building a relationship on the basis of trust with the patient, especially in the area of psychiatric assistance, if it is limited by the time of a visit or the impossibility of direct contact with the patient. One of the answers may be participation in the Balint group, which assumptions and goals are presented in this article, at the same time emphasising the importance of its activity for establishing physician-patient relationships. Balint group leaders come from different schools or therapeutic streams but regardless of this fact, their participation in the group consists of the acquisition of the ability to understand patients and communicate with them. Using such groups is highly beneficial to the physician-patient relationship because it provides the physician with broader professional experience, teaches concentration on the patient's problem and is also a factor preventing professional burnout.

Introduction

At the time of progressive development of medical technologies, diagnostics, and telemedicine, namely remote healthcare, we need to ask ourselves about the place and space necessary for a patient and physician to meet in a time limit, often restricted in a top-down manner provided for a visit. It is worth considering whether 10 minutes for an appointment with a family physician or another specialist will be sufficient to examine a patient, establish a relationship, and gain his trust, in the scope of which our patient will be ready to follow any medical dispositions. Apart from that, another question arises as to whether a physician is content with his working day

and whether he has a sense of a well-done job, and satisfaction and pride related with it. At present, complicated algorithms and schemes are implemented to reduce the waiting queues and replace contact with a physician but this gives rise to the reflection on whether medicine is still art, as results from its name (Latin *medicina* — art and practice of healing) or whether medical advice has become only a service performed by a physician in favour of a patient. It is also worth considering whether it is possible for a patient, *i.e.* a person who is sick, suffering and seeking help, to enter into a relationship with a physician via his smartphone, laptop, and installed applications.

The above-mentioned considerations in the period of the rapid development of technologies and frequently imposed dehumanisation in medicine plead in favour of rethinking the doctor-patient relationship. Currently, this problem is particularly pertinent due to limitations of personal contacts of patients with physicians, resulting from the spread of the SARS-CoV-2 virus. Until present, remote visits comprised one of the possible options of patient contacts with physicians but recently, they have become a necessity dictated by the epidemic situation. Within a very short time, recommendations arose as to what form such consultations should adopt. Both patients and physicians had to adjust to them in a fast and efficient manner [2]. It can be assumed that the remote form of contact with a patient will gain opponents, as well as supporters, wishing to maintain "distant" contact with their physician, even after removal of any restrictions. There are sets of applications available to patients responsible for lowering the level of anxiety and improving mood related to isolation and epidemic risk [3].

The epidemic situation has also caused in some cases the suspension of work in Balint groups. Therefore, the Polish Balint Society has organised one-day online seminars for persons working in aid-related professions, *i.e.* physicians, nurses, psychologists, therapists, teachers [4]. In a situation of intensive work, frequent due to the epidemic, the above-mentioned professional groups have faced new challenges, with a possible consequence of an increased need for protection against professional burnout and better communication with their dependants. Online meetings take place with the use of computer programs and applications, and participants are informed about technical requirements that must be complied with by the used equipment, so that the sessions would run smoothly and with no disruptions. This is certainly one of the possible "emergency options" in this difficult and urgent situation. Nevertheless, it needs to be emphasised that, by definition, the Balint group is based on direct contact of the group leader with its members, mutual observation and mindfulness to the gestures and mimic, which is highlighted later in this article. Certain significant symptoms may be easy to miss during remote contact or may be disrupted by technical factors that are beyond the control of meeting participants (*e.g.* overloaded Internet link). "Traditional" meetings may seem difficult or even impossible to organise at present but we must strive to sustain such a form of meetings, since direct contact of the group members is crucial to its course and achieved

results. It may turn out that solely remote work within the Balint group will prevent achieving all the effects related to its assumptions and will act as an ordinary "support group", if the direct contact between its members will be limited in the long run. This problem also applies to conducting individual or group therapy in the on-line format, in which direct contact — in particular with a new patient — is central to the success of aid activities.

A doctor-patient relationship requires constant concern for quality, as it constitutes a basis for effective therapeutic contact [5]. The way in which information is provided, the right choice of words, devoted time and non-verbal messages play an important role in the patient recovery process. Proper communication determines such factors of medical treatment as complete medical history of the patient, accurate recognition of diseases, the patient's reactions on the suggested treatment and their following satisfaction. Therefore, it may be concluded that it is a factor, which determines solving health problems of a patient [6], in particular in the operating field of a psychiatrist [7].

The literature presents the following models of the doctor-patient relationship, differentiating the mutual approach: 1) paternalistic 2) partner, 3) asymmetric, and 4) interpretational [8]. The first model of relations — paternalistic — is characterised by the subordination of a patient to a physician, who is the authority and, at the same time, assumes full responsibility for the treatment [9]. Consequences of such an approach may be visible in the passive attitude of a patient, who starts feeling dependence on the physician, simultaneously losing trust to them and making others responsible for their own health. On the contrary, in a partner model, it is assumed that a patient is an equal partner in the relationship [10]. It means that a physician cooperates with a patient and his family in the field of health education, prevention, diagnosis, and solving health treatment problems. The physician informs the patient about potential treatment options and their results but it is the patient who makes the final decision. In this model, a patient is treated as an equal partner in the relationship. Asymmetric relation consists in a dominant position of the physician with the provision that a patient independently chooses the level of engagement in the decisive treatment-related process and may have influence on the final course of the treatment [11]. The interpretational model assumes that the physician acts as an advisor for the patient who presents his "story" regarding the symptoms of their disease [12].

According to the literature, the doctor-patient relationship is subject to numerous changes, which is why the paternalistic model of relations is more often giving its way to the partner relation [13, 14], although patients sometimes prefer the paternalistic model [8, 15]. This may result from the significance of the environment, in which a meeting between a physician and a patient occurs. Every institution has its own norms regulating the method of contact with a patient, as well as cooperation principles [16].

Regardless of the adopted model of relations, it is important that the cooperation between a physician and a patient is treated as an interaction, in which mutual engagement of both the physician and the patient takes place, since both parties introduce significant individual contributions, *i.e.* their personality, temperament, life experience, specific worldview, and in the case of the physician – professional competence [17]. This relationship is characterised by many factors but the most essential among them, namely the one that builds mutual trust, is psychological comfort of the patient and showing empathy, understanding, attention, and kindness by the physician [16]. A question arises of how a physician should ensure such conditions for a patient, at the same time not forgetting about the professional burnout issue that every physician is exposed to [18], particularly when working with a psychiatric patient [19]. One of the possible solutions includes participation in a Balint group, which assumptions are presented in the subsequent part of this article. We would also like to stress the importance of its activity for establishing relationships between physicians and patients.

The Balint Group — Assumptions and Importance to the Doctor-Patient Relationship

Before we proceed to the description of Balint group assumptions, attention should be drawn to several essential facts from the life of Michael Balint that have contributed to the shaping of his opinions and his working method [20]. Experiencing two world wars by Balint, during which he dealt with people suffering from extreme situations and multiple traumas, is of great significance. As early as in the 30-ties of the 20th century, he carried out psychotherapy of patients with psychosomatic symptoms of a disease, on the basis of the assumptions of psychoanalysis that fascinated him while he attended lectures and seminars conducted by a follower of Sigmund Freud — Sandor Ferenczi. In the course of his further professional development, Balint subjected himself to psychoanalysis conducted by Ferenczi and drew from object relations theory that he gradually developed. Then, he conducted many seminars himself along with medical practitioners regarding the use of psychotherapy elements in everyday work within the field of psychoanalysis and psychosomatics. His medical and psychological education constituted a basis for his own work with patients.

His wife Enid, who — as a social worker — sensitised Balint to psychological and social factors in relations with patients also had a significant impact on his opinions. In 1950, they both set up a first group seminar composed of medical practitioners, focussing on the doctor–patient relationship, called “A discussion group seminar on psychological problems in general practice”. In 1957, Balint published his book entitled “The doctor, his patient and the illness” based on experiences acquired in the course of his work with physicians, which may be considered as a

turning point in his career. He also worked with students of medicine, with whom he started classes from 1969 on medicine based on patient subjectivity and their contact with a physician.

The Balint group concept was gradually spreading over the entire medical world [21]. In the period when it emerged, it was an entirely new phenomenon and relatively difficult to assign to the medical thinking then in force. However in time, as Balint assumed in his concept, this group has become a part of medical education that has put the doctor-patient relationship, which had been marginalised until then, in the spotlight. In accordance with the initial assumption, the Balint group was originally intended for physicians, who shared difficult emotions with patients. Balint repeatedly pointed out that a physician is the most important remedy for a patient [1] but — in order to be effective — he must take care of his own competence and psychological resources.

According to the founder, the Balint group is first and foremost responsible for the diagnosis of the doctor–patient relation [22]. Such a diagnosis (German *Beziehungdiagnose* — relation-based diagnosis) should enable a physician to undertake correct measures regarding subsequent therapeutic interventions in the scope of all activities aimed at improving a patient's well-being and alleviating his suffering (Greek *therapeuéin* — looking after, worshipping). The work in a Balint group allows for insight into the emotional relationship between a sick and a therapist. Proper contact with a patient, and primarily, understanding by a sick person the unaware symbol of his symptoms and body language are part of the relation diagnosis process. Such a diagnosis and its awareness on the side of a physician enables to communicate in a better way, as well as to avoid possible conflicts related to mutual, frequently sub-conscious expectations from both parties to the relation.

Research shows that from 20% to 30% of family physicians' patients do not show any somatic illnesses, and their suffering and medical visits result from unconscious stress, fear, or depression [23]. Such patients suffer subjectively, often feel misunderstood by their physician, disregarded, and even rejected. As a consequence, they seek help from other specialists, where a similar situation takes place. Their suffering and frustration are growing, leading to conflicts, dissatisfaction and persistent complaints. The physician, despite the fact that he wants to help his patient, senses his suffering and pain but also irritation. When a physician gets familiar with test results that explain nothing at all, he may outwardly assess the situation as such, in which a patient is healthy but "only makes everything up." In such a case the physician should reflect on the possibility that the patient's behaviour is probably unconscious and may be an expression of his internal suffering. If the physician fails to make such a reflection, as a consequence, the frustrated and dissatisfied patient will leave the physician's office, not entirely trusting his therapist, and the physician himself may be left behind experiencing anxiety and uncertainty. That may gradually incite mutual hostility, as well as cause irritation and anger. In the end, a feeling of dissatisfaction, unfulfilled expectations, and frustration remains on both sides of this relation.

It is important to point out that responsibility in shaping relations with a patient lies to a large extent with professionals, *i.e.* physicians or therapists. A patient is a person who comes to a physician with his pain, sadness, or fear. Thus, the physician is responsible for the quality of the suggested treatment but primarily for the quality of relations with the patient, which also belongs to the treatment process [14]. According to Balint, a physician should first of all properly recognise the needs of a consulted patient, understanding what they mean both for the patient, as well as for the physician himself [24]. Furthermore, as a professional, the physician should consider whether and in what form he is going to provide the patient with his perceptions and assumptions.

The aim of Balint training is to promote the doctor–patient relationship, practice designing professional relations, as well as examining one's own attitude in the relations with a patient [25]. The work in this form also prevents to a large extent the occurrence of professional burnout syndrome and comprises a tool maintaining and even enhancing the quality of work [26, 27]. In a broader perspective, the work in a Balint group is addressed to all professional groups connected with work with patients, *i.e.* physicians, nurses, therapists, social workers, ergotherapists, and physiotherapists.

Traditionally, a Balint group is composed of 8–12 participants, a group leader, and possibly a co-leader. The first meeting starts with the introduction of the participants and a discussion on the principles applicable within a Balint group, *e.g.* maintaining secrecy of its course, respect for other participants, their feelings and emotions, statements that are non-judgmental but describe one's feelings in the context of a presented case. A group leader is a meeting moderator, who takes care of the protagonist in an emotional sense, as well as about other group members. He is also responsible for the control of time frames of a meeting.

In the subsequent course of a session, one of the participants voluntarily reports a problem regarding his relationship with a patient. During the case presentation, the protagonist does not use any notes, abstracts, or any other medical documentation. The case is described from memory, with emphasis on the emotional side of a given situation. It should be stressed that the group course (the so-called setting) differs sometimes, depending on which Balint Society the leader originates from. In order to visualise such differences, two setting models of a Balint group course are briefly described — the Polish and the German model [21, 28].

In the Polish model of the Balint group, a problem presented by a protagonist may not only apply to a patient or his family but also to his co-worker or any other person engaged in the treatment. This is a broader perspective, since the discussed problem not always directly concerns the doctor–patient relationship. The German Balint group model is based on more orthodox assumptions. A patient and his relation with a physician are always in the first place. Discussing the

physician's relationship with a patient's family is acceptable, however, it is only a background to the basic doctor–patient relationship.

After the presentation of the discussed situation, every group participant gives his account of the feelings that accompanied him in the course of hearing the story. In the Polish model, the main focus is put on the feelings (*e.g.* anxiety, rage, irritation), and in the German model, psychosomatic experiences of participants are additionally underlined in a significant manner (*e.g.* abdominal pain, pressure in the head, trembling hands). In the consecutive round, every participant may specify the description of the discussed situation, asking the protagonist direct questions.

When there are no such questions, the protagonist in the German model symbolically moves his chair outside the circle (in the Polish model the protagonist most often remains in the circle) and until the end of the group session becomes an observer or mute participant of further deliberations. From that moment, none of the group participants should address the presenting party. In the German model, it is emphasised that even eye contact or other non-verbal contact should not be established with the presenting party.

The subsequent course of the group meeting in the Polish model is more structured when compared to the German model. Every group participant attempts to put himself in the shoes of the protagonist in reference to the given situation. Then, they empathise emotionally in the previously presented situation, considering how they themselves would feel in the shoes of the leader. This is not about giving advice or assessment of a given attitude but about insight into oneself and an attempt to understand a given stance, and mostly, the emotions of the protagonist. In the subsequent part, the participants put themselves in the shoes of the person that the given situation regarded, namely the patient or/and his family. The participants ask themselves how they would react in a given situation and what emotions could be associated with it. Eventually, every participant suggests a solution to the given situation in the light of the discussed case.

The Balint group in the German approach works more psychoanalytically than the group in the Polish model. There are no subsequent rounds, in which participants put themselves in the shoes of a protagonist or a patient. In addition, no advice is attempted to be given nor any specific solutions are searched for. The work is based more on the emotions felt, free associations and own experiences, often not realised until that time. A group moderator during its course tries to name specific reactions of participants, clarify or reflect them in the context of a discussed case. In the last part of a meeting, the protagonist comes back to the circle of participants. The leader gives floor to the protagonist, who may, but does not have to, share his emotions with the group, that he has experienced while listening to the work of the group. The persons presenting various situations often feel relieved, understood by the group that presents similar emotions and feelings. It may also turn out that a group cannot understand the protagonist's emotions or his problem. The moderator's role

consists in that all the group participants should feel safe within the meeting, therefore, he must ensure that all the emerging emotions — the negative ones in particular — would not focus on one of the group members.

Interestingly, according to research, 30.6% of the Balint group leaders in Germany have a specialisation in psychosomatics and psychotherapy, 17.1% in psychiatry, and 12.3% are family physicians [29]. We have not accessed detailed Polish data, however — analysing the list of leaders qualified to conduct a Balint group individually — it may be concluded that psychotherapists, psychiatrists, and psychologist dominate among them — mainly with a clinical specialisation [30].

A Balint group meeting takes an hour and a half, during which it is most often possible to discuss two cases presented by the participants [31]. The groups meet depending on the reported needs, *e.g.* every two weeks or once a month. They may have an open form, in which participants of the meeting change, or a closed form, when the group members agree upon a given number of mutual training. An advantage of closed Balint groups over the open ones is that the participants in the course of subsequent meetings become more open in demonstrating and naming their emotions. What is more, everybody is familiar with the course of the group activities, which allows for more dynamic and effective work.

Conclusions

Balint group participants come from various medical environments or specialisations but their participation in such meetings consists in the acquisition of the skills of understanding patients and communicating with them [25]. The Balint group is deemed to be an effective tool for work also with hospice patients [32, 33], the disabled [34] and also found partial application in coaching work [35].

The use of a Balint group brings tangible benefits to the doctor–patient relationship, it is also significant for the physician himself, as well as for the other participants. Participation in a Balint group provides a physician with professional experience that gradually leads to a change in his personality [1]. Group participants learn how to concentrate on a patient and his experience more extensively, thus obtaining a general insight into the entire problem. In the longer term, they realise that there are other psychical, social, or family factors apart from the somatic disease that may entail the development of symptoms of a disease. Specialists claim that they also develop the feeling of coherence among Balint group leaders [36]. Another benefit is that a treating physician can see his limitations related to providing help to others, as well as the possibility to improve relations with a patient [37]. Drawing on the experience of group participants, a physician is often able to distance himself from a given situation and see it from the patient's perspective, obtain a better understanding and work satisfaction.

Nevertheless, the most important aspect and profit related to work in a Balint group is the revision of a personal relationship with a patient. As early as during the studies, bases for further work of a physician with an ill and suffering person are established. In the course of subsequent professional development, a physician acquires knowledge and experience, and patients, the working environment, and the current situation in the healthcare system shape medical standards and professional schemes of a physician. Sometimes, it happens that patience, sympathy, compassion, involvement, and selflessness ”get lost”. Impatience, suspicion, and anger, followed by professional burnout emerge instead, causing patients, physicians and their nearest environment to suffer. With a tool like the Balint group, a physician can always re-diagnose his relation with a patient, and – if necessary – attempt to change it or simply accept his limitations. An active attitude in this field of professional self-development enables to achieve greater work satisfaction that will protect such a physician against professional burnout, but primarily will ensure better care for his patients.

References

1. Balint M. The doctor, his patient and the illness. London: Pitman Medical; 1964.
2. https://www.gov.pl/web/rpp/poradniki-dla-pacjentow-oraz-lekarzy-dotyczace-zasad-korzystania-z-teleporad (accessed 23.05.2020)
3. https://www.mp.pl/pacjent/psychiatria/aktualnosci/237424,smartfonowe-aplikacje-dbaja-o-psychike-podczas-epidemii (accessed 24.05.2020)
4. https://balint.pl/bol10-1-08-2020/#more-891 (accessed 29.08.2020)
5. Ogłodek E, Moś D, Araszkiewicz A. Zasady kontaktu terapeutycznego lekarza z pacjentem. Zdr. Publ. 2009; 119(3): 331–334.
6. Włoszczak-Szubzda A, Jarosz MJ. Rola i znaczenie komunikacji w relacji lekarz–pacjent–rodzina. Med. Ogólna i Nauki o Zdr. 2012; 18(3): 206–211.
7. Sosnowska M, Prot K, Chojnowska A, Kobayashi J, Nurowska K, Kalinowski A et al. Czynniki powiązane z relacją terapeutyczną w ocenie chorujących psychicznie i ich terapeutów — wyniki badań w psychiatrycznej opiece środowiskowej i ambulatoryjnej. Post. Psychiatr. Neurol. 2012; 21(4): 259–267.
8. Krot K. Determinanty współczesnego modelu lekarz–pacjent. In: Lewandowski R, Kautsch M, Sułkowski Ł, ed. Współczesne problemy zarządzania w ochronie zdrowia z perspektywy systemu i organizacji. Łódź: Wydawnictwo Społecznej Akademii Nauk; 2013, pp. 349–360.
9. Cullen R. Empowering patients through health information literacy training. Health Educ. 2005; 54(4): 231–244.
10. Lagerlov P, Leseth A, Matheso I. The doctor–patient relationship and the management of asthma. Soc. Science Med. 1998; 47(1): 85–91.
11. Elwyn G, Edwards A, Kinnersley P, Grol R. Shared decision making and the concept of equipoise: the competences of involving patients in healthcare choices. Brit. J. General Pract. 2000; 50(460): 892–899.
12. Eriksson T, Nilstun T, Edwards A. The ethics of risk communication in lifestyle interventions: Consequences of patient centeredness. Health, Risk Society 2007; 9(1): 19–36.
13. Hausman A, Modeling the patient-physician encounter: improving patient outcomes. Acad. Mark. Sci. J. 2004; 32(4): 403–417.
14. Jankowska AK, Pałgan I, Dylewska K, Grześk E, Wysocki M, Sadowska-Krawczenko I. Komunikacja lekarz–pacjent a jakość opieki medycznej. Polskie Stowarzyszenie Zarządzania Wiedzą. Series: Studia i Materiały 2011; 54, 199–207.

15. Tapp L, Elwyn G, Edwards A, Holm S, Eriksson T. Quality improvement in primary care: ethical issues explored. Int. J. Health Care Qual. Assur. 2009; 22(1), 8–29.
16. Ratajska A, Kubica A. Co leży u podłoża złej współpracy lekarz–pacjent? Spojrzenie Psychologa. Folia Cardiol. 2010; 5(2): 84–87.
17. Spake D, Bishop J. The impact of perceived closeness on the differing roles of satisfaction, trust, commitment, and comfort on intention to remain with a physician. Health Marketing Quarterly 2009: 26(1): 1–15.
18. Sęk H. Poznawcze i kompetencyjne uwarunkowania wypalenia w pracy z chorymi. Post. Psychiatr. Neurol. 2005; 14(2): 93–98.
19. Makara-Studzińska M, Tylec A, Kudlik A, Matuszczyk M, Murawiec S. Analiza zjawiska wypalenia zawodowego w grupie lekarzy psychiatrów – przegląd badań. Psychiatria 2018; 15(1): 35–38.
20. Engel L. Michael Balint — życie i dzieło. In: Wasilewski B, Engel L, ed. Grupowy trening balintowski. Teoria i zastosowanie. Warszawa: Eneteia; 2011, pp. 15–21.
21. Wasilewski B, Kiliszek B. Ruch Balintowski w Polsce i na świecie. In: Wasilewski B, Engel L, ed. Grupowy trening balintowski. Teoria i zastosowanie. Warszawa: Eneteia; 2011, pp. 253–262.
22. Balint E., Norell JS. Six minute for the patient. Interactions in general practice consultation. London: Travistock Press; 2001.
23. Czachowski S, Buczkowski K. Pacjenci z zespołem MUS w podstawowej opiece zdrowotnej. Wskazówki diagnostyczne i terapeutyczne. Forum Med. Rodz. 2015; 9(1): 38–44.
24. Petzold ER, Otten H. Balint leadership training intensive. Balint J. 2005; 6(2): 55–57.
25. Kaflik I, Łazowski J. Podstawy teoretyczne i praktyczne balintowskiego treningu grupowego. Sztuka Leczenia 2017; 1: 85–95.
26. Kjeldmand D, Holmström I. Balint groups as a means to increase job satisfaction and prevent burnout among general practitioner. Ann. Fam. Med .2008; 6(2): 138–145.
27. Wasilewski B. Grupy Balinta w profilaktyce wypalenia zawodowego. In: Wasilewski B, Engel L, ed. Grupowy trening balintowski. Teoria i zastosowanie. Warszawa: Eneteia; 2011, pp. 161–176.
28. Rosin U. Balint – Gruppen: Konzeption – Forschung – Ergebnise. Berlin Heidelberg: Springer Verlag; 1989.
29. Häfner S, Otten, H, Petzold ER. Praxis der Ballintgruppenarbeit in Deutschland – Ergebnis einer Umfrage unter Leitern von Balintgruppen. Z. Psychosom. Med. Psychother.2011; 57(3): 233–243.
30. http://balint.pl/liderzy/ (accessed 24.05.2020)
31. Kaflik I, Motyka M. Metody pracy grup balintowskich dzisiaj. In: Wasilewski B, Engel L, ed. Grupowy trening balintowski. Teoria i zastosowanie. Warszawa: Eneteia; 2011, pp. 91–104.
32. Stelcer B. Grupy Balinta w szkoleniu personelu hospicyjnego. Twój Mag. Med. 2005; 1(5): 13–15.
33. Stelcer B. Grupy Balinta w opiece terminalnej. In: Wasilewski B, Engel L, ed. Grupowy trening balintowski. Teoria i zastosowanie. Warszawa: Eneteia; 2011, pp. 179–188.
34. Stelcer B. Grupa Balinta jako narzędzie doskonalące relacje z niepełnosprawnym pacjentem. Przegl. Bad. Eduk. 2015; 21(2): 233–246.
35. Jastrzębska A. Grupy Balinta w praktyce coachingowej. Elementy psychoanalizy. Coaching Rev. 2015; 1(7): 59–69.
36. Kiliszek E. Trening balintowski jako rozwijanie poczucia koherencji u liderów — uczestników grup Balinta. Sztuka Leczenia 2013; 3–4: 9–16.
37. Zgud J. Grupy Balinta w szkoleniu psychoterapeutów. In: Wasilewski B, Engel L, ed. Grupowy trening balintowski. Teoria i zastosowanie. Warszawa: Eneteia; 2011, pp. 151–160.

E-mail address: pmichalska@ukw.edu.pl