Burnout Among General Hospital Mental Health Professionals and the Salutogenic Approach

Stanley Rabin, PhD, Yuval Shorer, MD, Meir Nadav, MA, Jonathan Guez, PhD, Mali Hertzanu, MSW, and Asher Shiber, MD

Department of Psychiatry, Soroka University Medical Center and Division of Psychiatry, Faculty for Health Sciences, Ben-Gurion University of the Negev, Beer Sheba, Israel

ABSTRACT

Professionals working in mental health often exhibit high levels of strain leading to poor psychological well-being, emotional exhaustion and depletion of personal resources. Even under tight global economic conditions preventing burnout should be given high priority among mental health providers. This paper looks at the wide spectrum of stressors found in specialists working in the mental health area and examines, with the salutogenic approach in the background, ways to relieve professional burnout among general hospital mental health providers. Guidelines for managers and staff to alleviate their professional strain are suggested so as to improve the quality of life in the workplace.

THE NATURE AND CONSEQUENCES OF BURNOUT

Burnout is a set of symptoms associated with chronic stress in a variety of occupations (1, 2). These symptoms include emotional exhaustion, physical fatigue and cognitive weariness (3, 4). Burnout has been consistently related to work performance, job satisfaction, quality of life, and psychological well-being, and positively related to withdrawal behavior. It may, in some cases, precipitate health professionals leaving the profession completely. Other consequences include lowered productivity, increased absenteeism, increased health care costs, role and professional conflicts, and difficulties of making decisions in a changing health system (5, 6).

Occupational stress has been recognized as being detrimental for emotional and physical well-being (2). It has been associated with a variety of negative emotions such as anxiety, depression and anger, being the causal factors in a variety of work-related conditions including absenteeism and job related, interpersonal conflicts. Stress has been found to be related to cardiovascular illness, gastrointestinal conditions and may alter immune functioning (7). The outcome of prolonged strain can culminate in exhaustion and depletion of personal resources. It can lead to substance abuse and self-medication and ultimately to possible professional errors and even medical misconduct. Suicide and external injury and poisoning (8, 9), for example, have been found to be some of the reasons for doctors' deaths. Evidence has also shown that male doctors (aged 20-74) have a significantly higher proportional mortality ratio for viral hepatitis, liver cancer and cirrhosis, and women doctors (aged 20-74) have a higher ratio for cancer of the pancreas (10).

BURNOUT IN MENTAL HEALTH PROFESSIONALS

There is growing evidence to support the claim that mental health professionals, by the nature of their work, are particularly vulnerable to stress with all its detrimental effects on service delivery and quality of care. (11-13). Differences have been found between mental health staff working in community mental health clinics and psychiatric hospital settings. In the latter, strain includes feelings of lack of autonomy, responsibility without authority (14) and possible restriction in ability to develop independent psychotherapeutic roles. Community mental health workers, on the other hand, have reported finding their contacts with patients highly rewarding, yet their sources of strain may involve feelings of over-responsibility for the well-being of their patients. Mental health workers working in the private sector perceive more control over their professional lives. However, the sources of stress in this group may

Address for Correspondence: ✉ Stanley Rabin, PhD, Psychiatric Department, Soroka Medical Center, POB 151, Beer Sheba, Israel.
stanleyra@clalit.org.il

involve other factors, like the loneliness of private practice and networking for new referrals.

On a broader system-level perspective, health policy may affect professional stress when there are sometimes insufficient resources available for mental health. Long waiting lists, due to manpower shortages, often make professionals in the field feel that they are doing piecemeal work, giving unsatisfactory treatment or overusing pharmacological treatment. Problematic features in the clinician-colleague-boss triad, and workers' personal home-work conflicts may be stressful areas (15, 16). Mental health workers sometimes perceive administrators and health financial advisors as over-managing decision-making (10). Too much control may lead mental health workers to feel helpless in controlling their own professional lives.

THE SALUTOGENETIC APPROACH

More than three decades ago, Aaron Antonovsky looked at factors allowing individuals to stay healthy and manage stress in the face of adversities (17, 18). He claimed that people who remain relatively healthy in the face of threats have within themselves a certain approach to looking at the world. He formulated his now well known Sense of Coherence Concept (SOC). SOC involves a particular orientation, a certain view of the world and comprises of three main components: comprehensibility, manageability and meaningfulness.

Comprehensibility refers to the way in which the person is always in a mutual relationship with his/her environment, gaining understandable structure from it. This involves placing one's environment in order, to classify it and structure the stream of information and stimuli, which often overwhelm us. Comprehensibility is the cognitive component. Manageability, the behavioral component of the SOC, is the way we influence and cope with the environment, using positive resources to control it. Meaningfulness, the emotional component, is what makes sense to us. It involves those demands that the person sees as challenges, perceives as worthy of investment and engagement and the pursuit of finding meaning in committing oneself to the task.

Antonovsky (17) used the concept of "generalized resistance resources" (GRRs) each of which can facilitate avoiding or combating a wide variety of stressors; examples are money, shelter and food; intelligence and knowledge; social support; and rituals and religion. GRRs help persons understand and make sense out of the many stressors they constantly have to face (17). When the person regularly experiences the availability of GRRs, a strong SOC develops.

Much research worldwide has been done in the area of SOC, especially in the health area. In a review article (19) which included 458 scientific publications and 13 doctoral theses about SOC it was found that regardless of age, sex, ethnicity, nationality and study design, SOC was strongly related to perceived health, especially mental health. Here it was reported that evidence substantiates the salutogenic model as a health promoting resource that improves resilience. It was also found to develop a positive subjective state of both physical and mental health, quality of life and well-being. In the mental health area a recent study by Griffiths (20) found substantial evidence indicating that sense of coherence plays a central role in coping with stressors in the rehabilitation/recovery process and that it contributes to mental health and psychosocial functioning. They maintain that if rehabilitation services adopt a salutogenic approach and seek to enhance a client's sense of coherence this can be beneficial in the client's rehabilitation and recovery.

Among psychotherapists, the SOC concept has been found to be positive in combating professional stress. In a study by Linley et al. (21) the sense of coherence personality construct was found to be the factor most protective against negative psychological changes and compassion fatigue, while sense of coherence and the therapeutic bond were the factors most protective against burnout. Linley and Joseph (22) later report that sense of coherence was associated with therapist well-being.

The salutogenic approach, in contrast to the pathogenic one, asks: what are the factors that induce an individual to preserve his or her health in times of tranquility and stress in order to develop a sense of coherence? To reach a sense of coherence regarding burnout of mental health professionals in the workplace, we may also ask ourselves various questions which include: What are the reasons for professional stress for this professional group? How can these professionals manage their stress? How can they find meaning in the workplace? Is burnout neglected among those who constantly provide help to others, and who focus on others' well-being? In order to answer some of these issues, we initially engaged in a process of self-exploration where we looked at practical interventions for relieving professional burnout.

It can be assumed that the strengthening of SOC is possible, and that it can serve as a framework for initiated and planned positive change in the health systems.

Rabin et al. (10) kept this approach in mind when suggesting many of their possible intervention strategies. They suggested that by implementing some of their proposed strategies a better sense of coherence could be achieved, leading to reduced burnout.

The relationship between SOC and burnout has been described in various articles in the professional literature (23-25). In a recently published article, Van der Colff and Rothman (26) found in their sample of 818 registered nurses that the experience of depletion of emotional resources and feelings of depersonalization (related to burnout) were associated with a weak sense of coherence. Work engagement was predicted by strong SOC approach coping strategies.

We now propose several possible interventions for burnout based on the SOC framework. We will illustrate each approach with a case vignette or details from our own experience.

INTEGRATED TEAM MEETINGS

The differentiation of professions into specialized sectors (psychiatrists, psychologists, clinical social workers and paramedical staff) often leads mental health specialists to estrange themselves from other professional groups. This may keep them isolated in their psychotherapeutic rooms, often leading to feelings of loneliness and professional estrangement. Every sector may see patient issues in its own well-defined and restricted way, without considering the perspective or enrichment that the other sector may provide.

The setting up of interdisciplinary team meetings may serve as a venue for professional discourse and collaboration, helping different professionals to learn to understand the dilemmas of the other. A case vignette, being a real experience of the authors, will now be discussed

Case vignette. At a multidisciplinary team meeting, a psychologist spoke about the psycho-diagnostic tests that she had performed. Other psychologists in the team suddenly and rather unexpectedly expressed their reservations about the time consuming aspects of psychological testing, and questioned even if they were at all worthwhile. This surprised the other professionals of the team. It brought into the open a secret not expressed explicitly to other sectors before. A discussion about the usefulness of testing in diagnosing patients and the use of pharmacological treatment by the psychiatric sector then ensued. The psychiatrist in the team then expressed the difficulties and frustrations he sometimes had in the pharmacological treatment of PTSD patients. The interdisciplinary team allowed these "forbidden" secret subjects to be openly revealed. This allowed for candid interdisciplinary discussion about professional secrets that were never spoken about before, with professionals from "the other side." It also broke down the myth that "the other side" has some special, secret trick, "that they have something better than us, something that really cures." By understanding "the other side's dilemmas" (comprehensibility) the team became more cohesive and the subsequent interactions between the professionals more meaningful.

BALINT GROUP WORK

Talk about job stress, corridor consultation and passageway chats are other ways in which health workers often relieve their frustrations. These are informal encounters between clinicians, where cases are discussed for a few moments, and temporary relief acquired. While these are not ideal solutions for discussing staff burnout, it may be seen to be effective in some instances. However, these are often sporadic and chance meetings, lacking the formal and containing aspects present in organized group meetings.

Channeling feelings in a group setting allows members of staff to understand common dilemmas and learn to manage and share their similar emotionally-laden work with one another. One such type used in the health area as an effective way of treating burnout is the Balint group (27). Balint groups were at first seen as essentially dynamic work discussion groups with the doctor–patient relationship as the focus (28). While they lead to a deeper understanding of patients' psychosocial issues, they may change the way the clinician perceives him- or herself. This is done when clinicians, with the guidance of one or two leaders, discuss various aspects of the clinician-patient relationship. The group encourages its members to listen to the patient instead of using the traditional style of history-taking (29).

The supportive and non-threatening aspects of the group allow clinicians to legitimately discuss their emotions within the context of their work and to manage stress in the face of their difficulties, in the salutogenic mode. Balint groups have been largely run for general practitioners. However, primary care physicians (general practitioners and other medical specialists working in the community) have also benefited from these groups (30), as well as clinical psychologists (31) and psychiatrists (32, 33). We propose that Balint groups be formed for mental health personnel too to be run by outside leaders who are not part of the team, in line with the first groups set

up by Michael Balint himself as he gathered together GPs from their various practices in the Greater London area. These groups help in sharing and reflection and it should be pointed out that professional interchange between colleagues in a group setting empowers participants, leading to possible reduction of feelings of burnout (30, 34).

BALINT GROUP EVALUATION. PILOT STUDY

Although the above reviews and recommendations are base on theoretical data and the authors' experiences, we add some initial data collected from two groups, one a physician group and the other a multi-professional hospital ward group in which outcome measures were taken.

It should be noted that it is often difficult to get the participants' cooperation to evaluate the intervention due to time demands, work pressures and the mental effort necessary for doctors completing questionnaires. We found that doctors are the "hardest to get." Thus we present here a partial picture of those participants who were willing to answer our anonymous questionnaire.

The first set of data was collected from a group of doctors participating in a Balint group. Two psychotherapists from the Psychiatric Department were asked to assist setting up a group in a very demanding peripheral clinic where the manager felt that her doctors were exhausted and burned out. The therapists accepted the challenge. We explained to the manager that he could not participate in the group or involve himself with the processes within the group meeting. In order to formulate the group setting, doctors met for one hour in a quiet setting where they would take a break from their work and secretaries were informed and respected this initiative. The therapists determined 10-12 meetings for intervention. Notwithstanding the difficult and at times the varied conditions, the group ran well through the process. Out of eight participants, six filled in the short questionnaire (10 items, 1-5 Likert scale), relating to five domains. See table 1. The results cautiously suggest that the participants evaluated the goup positively.

Table 1. *Means and standard deviations for the five domains*

	Mean	SD
contribution and change in me as a result of the group	3.1	0.6
supportive and accepting atmosphere	3.5	0.7
relevance for the participants	3.8	0.47
necessity of the group	3.4	0.54
general assessment	4.25	0.5

The second Balint group was multi-professional, made up of doctors, nurses and the social worker from our Nephrology Unit. The ward nurses and the social worker and the staff met once weekly on the ward for 12 meetings with a monthly follow-up session after the completion of the initial sessions. A burnout questionnaire was given to the participants before and after the Balint group. This questionnaire contains 14 items (1-7 Likert scale) with a high score presenting high levels of burnout. The pilot data, taken from two doctors and five nurses, showed a tendency for decreased feelings of burnout after the intervention. Mean score before the intervention was 37.8 (17.5) and 34.2 (13.9) after the group ended. No statistical analysis was done due to the low number of participants.

CO-LEADERSHIP OF PATIENT GROUPS ON THE PSYCHIATRIC WARD

Setting up specific patient groups for well defined problems (for example: eating disorder groups, midlife crisis groups) may be another way to prevent professional stress. The group leaders came from different disciplines that were themselves supervised in regular ongoing leadership group meetings. Co-leadership of these patient groups by different mental health professionals helped to contain the often monotony of treating regular individual patients for psychotherapy. It diversified their work by enabling them to function together in a group context, working for a common goal.

For example, we have a group of patients with eating disorders supervised by a social worker and a psychologist. Usually, the social work perspective emphasizes the system of which the individual is part, while (in our case) the psychologist emphasizes the inter- and intrapsychic conflicts. The co-leadership needed to feel this gap and that was done in many hours of discussing the group and the interventions that were used. This kind of interaction enhances the need to think of what you are doing and not do things just because "that is the way I/you studied it." After five years of co-leadership both therapists evaluated this co-leadership as the highlight of their work in those years.

MANAGERIAL SUPPORT IN INTERVENTIONS

The SOC concept has been used in studying managers' SOC dispositions in carrying out their work effectively. It has rarely touched on the SOC characteristics that can produce change in organizations.

Strumpfer (35) argued that in an organizational

environment, persons with an orientation towards a strong sense of coherence would experience productive performance and recognition. In such an environment such individuals will cognitively comprehend workplace intricacies and stressors in the SOC mode, so that they may make sense of the workplace complexities, perceiving its stimulation and information as clear, ordered, structured, consistent and predictable. This will help them to recognize their work demands as consisting of experiences that are manageable with which they can cope. This will help them to make sense of stressors meaningful to them and make emotional and motivational sense of work demands. Being equipped with high SOCs allows them to consider them as welcome challenges, worthy of engaging in and investing their energies in work. Later Semmer (36) summarized a number of studies, indicating that a sense of coherence is positively related to a number of indicators of well-being and health, as well as with working conditions.

In this context, we maintain that managers in mental health may be seen to be good containers of stress in understanding and carefully listening to their workers' issues. This requires them to adopt careful listening skills, to comprehend workers' stressors and work problems in order for them to be understood. Listening here does not mean interpreting process or providing psychodynamic explanations for staffs functioning, since this may be counterproductive in the sophisticated milieu of the mental health team.

"Deep listening" allows managers to take special note of the possible underlying motives and meanings of the behavioral outcomes of professional stress expressed in worker absenteeism, late arrival at work, low productivity and frequent sick leave. This requires them hearing "the language of professional stress" and "listening to the unspoken words" of burnout, often played down and subtle. Detection of burnout may be looking at it primarily as "the external story," ignoring alternative, untold systemic or personal narratives since the dominant story of "burnout" is sometimes used as a wastepaper basket, into which all descriptions and explanations of problems in "everyday life in the workplace" are thrown. By so doing, individual and shared experiences are not taken into account, which may be unexpressed, and unrecognized as possible alternatives for solutions to problems.

Comprehensibility in the SOC mode involves managers carefully deciphering why workers may not want to engage other colleagues in their stressors. This may be, for example, because of mental health workers difficulties in openly expressing weakness within the social context of their work, or their assumption that these issues are not acceptable for discussion in their working milieu. Therefore, it is very important for managers to try to understand these cues since immediate intervention in helping distressed employees may be done through managerial intervention. In more severe cases, workers can be referred to an Employee Assistance Program (EAPs), a service provided by some employers. This service, maintained by professional mental health specialists, helps employees through short-term therapy, to effectively manage personal problems that might have a negative effect on their well-being and consequently adversely affect their work performance. By understanding their employees' difficulties managers can help their workers to appropriately manage their conflicts. Referral of employees to EAPs may be one such meaningful manageable intervention here.

Mental health managers often realize how psychotherapists are over-demanding of themselves and their abilities, searching for the ultimate cure and perfect success in treating their patients. In this context managers should try to help their workers manage some of these subjective stressors. This can be done by guiding psychotherapists to uncover more realistic attitudes about expectations of cure and treatment, in order to consider patients' change (and their own expectations) in a more appropriate, realistic light.

Understanding the loneliness of psychotherapeutic work may help managers become aware of the emotional drain incumbent in constantly treating patients. This often creates feelings of isolation and seclusion by psychotherapists in their psychotherapeutic work. A way in which managers could help psychotherapists manage their difficulties and overcome these feelings may be to encourage them to rise above profound isolation by seeing patients together, for example, through joint scheduling mentioned earlier. This activity enables managers to realize the importance of adhering to an inter-professional cultural approach, rather than complying with a narrow uni-professional culture (37). In this context, joint cases may be seen together, treatment modes discussed and considered from different perspectives, enriching therapeutic skills by increasing professional competency and bolstering enthusiasm.

Consultation and liaison with community-based HMOs and other community agencies can be considered by managers as another way of preventing professional loneliness and stagnation in their workers. This involves

being open to hearing other professionals' viewpoints, attitudes and language. It requires a shared philosophy of care, a flexibility and openness in listening and attitude. The strength of effective teamwork and consultation, collegial support and liaison with other medical personnel units and outside agents may be seen as an effective buffer against feelings of professional loneliness and isolation.

Another reason for burnout may be related to workers (often older ones) not feeling updated in terms of their professional skills. Comprehending this deficit may help managers understand that feeling professionally competent may be seen as a way of gaining fulfillment too (38). This may help them to provide these workers with ongoing individual case supervision or didactic teaching modules, since educational interventions, emphasizing and enhancing professional skills and competency of staff have been found to be another effective way of reducing stress (38, 39).

Overload may have detrimental effects on the psychological equilibrium of staff. Therefore a more reasonable and balanced caseload may be seen to be effective in reducing such stress. Balancing the case allocation, for example, involves providing staff with a mixture of difficult and easier cases, and acute and chronic ones.

Where broader, system intervention is necessary the importance of calling on external professionals for help may be encouraged. This may involve, for example, turning to organizational psychologists to provide their expertise and professional guidance for organizational change.

Staff should be encouraged, of course, to partake in regular exercise, eat-right programs and regular leisure time activities and should be supported to take regular vacations, as a way of keeping a well-balanced psychological equilibrium. Joint team activities outside the clinic are also suggested. But it should be pointed out that the basic thrust of our paper is to look at the burnout phenomenon and its interventions within the professional group itself and not only reducing stress through providing some of the external activities described above.

CONCLUSION

This paper focuses on the "language of professional stress" for the mental health worker. As suggested, we found that these professional groups have unique variables that lead them to more vulnerability to burnout. Through adopting the salutogenic approach one can draw guidelines for intervention with suggestions for both managers and workers to improve their working environment. One aspect of primary prevention of professional stress and burnout may be to lecture about the subject in academic courses related to psychotherapeutic interventions. Furthermore, a professional trainer with knowledge of burnout may also be considered helpful to young professionals at the beginning of their careers. Also, the very writing of this paper by professionals from a wide spectrum of mental health disciplines (psychologists, psychiatrists and social worker) can be seen as a meaningful way to inject a particular, creative challenge into our mental health profession.

While we did collect some initial outcome data regarding the proposed interventions, it is important to note that our data are mainly descriptive, and therefore we cannot conclude that there was any direct impact (positive or negative) on burnout or occupational stress. In the future, we propose that researchers consider collecting more data on the proposed intervention or interventions, such as the MBI (Maslach Burnout Inventory) or other markers of occupational stress among participants, along with demographic data. The field could be benefited by a more systematic and scientific approach toward studying such interventions.

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