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Sitting in — or Sitting out?
A Discussion about Group-leading (2010)

Anne Tyndale and John Salinsky

You may have noticed that we now have two slightly different models of conducting a Balint group. In the 'traditional model', when the presenter has finished speaking, a general discussion follows straight away, with the presenter taking a full part.

In the newer variation, after the case presentation, the leader asks the group if anyone has any questions of a purely factual or clarifying nature to put to the presenter. Questions such as 'how does this patient make you feel?' are excluded at this stage. The leader then invites the presenter to move their chair back a few symbolic inches and remain silent for the first part of the discussion. After about 20 minutes, they are then invited to rejoin the group fully, for the rest of the session. This is called 'sitting out' or sometimes `pushback' (referring to the movement of the chair).

The point of sitting out, according to those who favour it, is that it blocks the overeager interrogation of the presenter, which is often a problem for the leader at the beginning of the discussion. Once the factual questions have been dealt with, the presenter is free to listen and reflect on what she hears without having to answer questions. The group, meanwhile, are thrown back on their own resources and have to work on the case themselves, by examining their own thoughts and feelings about the story they have heard.

Some group leaders are very enthusiastic about sitting out. Others think that it detracts from the flow of the traditional group process with its free association and the phenomenon of 'parallel process' in which the presenter and the group mirror the interaction between patient and doctor.

[1] First published 2010, Vol. 38, *Journal of the Balint Society*.

Where and when did sitting out begin?

It began in Germany, but we are not sure exactly when. According to Heide Otten of the German Balint Society it was often used on an occasional basis when it seemed to be appropriate. Perhaps if the questioning of the presenter was getting too prolonged and too intrusive. Balint doctors from other countries experienced it at International Congresses and it became popular in Scandinavia and Britain, Australia and the USA. Sitting out has been used as a matter of course in the very successful American Balint Society Intensive Leader Training courses for a number of years. It seems to be used much less in France and Belgium. The present position in the UK is that some groups and their leaders use sitting out while others stick to the traditional model.

The London Group Leaders Workshop Discussion

On 11 February 2010, the London Group leaders' Workshop devoted one of its meetings to a discussion of the relative merits of the two models.

Those present were Doris Blass, Tessa Dresser, Andrew Elder, John Salinsky, Oliver Samuel, Lenka Speight, Heather Suckling, Anne Tyndale and David Watt.

What follows is a summary of the main points made for and against the sitting out model:

Points against sitting out

- It makes the discussion less alive because the identification with the patients and the projections which the presenter may be carrying are put aside.
- There is awkwardness when the presenter comes back in and they sometimes feel a pressure to 'report back' on the discussion they have heard.
- The presenter may feel identified with a repulsive or rejected patient and therefore discarded from the group.

Points in favour of sitting out

- It makes the task easier for the leaders who no longer have the burden of trying to get the discussion into the group rather than continuing as a question and answer session with the presenter.
- Sitting out is sometimes useful if the group gets stuck.
- An example was given of a group which was nagging the presenter to say why she found the patient repulsive; she didn't know and when she withdrew, the freer discussion brought up ideas.

There was a feeling that Sitting Out had been adopted in most countries and might soon become worldwide practice. But that didn't mean that we all have to do it!

This led to a consideration of *The Aims of a Balint Group* which were thought to include:

- To facilitate free association as effectively as possible.
- To help all the members to think about the patient in relation to themselves as well as the presenter so that all can benefit.
- To facilitate 'the limited though considerable change in personality' which was the Balints' ideal result. This seemed to imply a move towards withdrawing one's own projections from the patients and being able to deal with the patients' projections onto the doctor. This would lead to a capacity to relate to a wider range of patients.
- To help the doctor and the patient to be seen as human.

Other issues about the format

There should be at most a low table in the middle of the group and not a high table.

Should group members be allowed to eat biscuits?

Should note-taking be discouraged or permitted? (It sounded as if the doctor in one group who regularly took notes was allowed to get on with it without much comment).

There was a general consensus that there should be no rules. This meant no rules about whether the presenter should stay in or withdraw for a while; and no rules about asking factual questions at the start.