The American Journal of Psychoanalysis, Vol. 62, No. 4, December 2002 (© 2002)

THREE TESTIMONIES ABOUT MEETING MICHAEL BALINT AND HIS IDEAS

Pierre Benoît was a general practitioner who became a psychoanalyst without abandoning completely his medical practice. He was the family doctor of the Dormandi family and had several occasions to meet and have discussions with Michael Balint. Dr. Benoît was very much interested in the Balint groups; he was leader of one of them, but not without trying to go further. Most of his ideas are expressed in a special number of the review Le Coq-Hèron n 95. This short testimony indicates in what direction he develops his thoughts. Dr. Benoît submitted his contribution shortly before his death on September 19, 2001.

Judith Dupont

A MEETING WITH MICHAEL BALINT

This is the account of my recollection of one of my meetings with Balint. This recollection may initiate some reflection about the object of the Balint method going beyond what is generally assigned to it: the analysis of the doctor–patient relationship.

It is the recollection of a meeting with Balint, Mrs. Balint, Ginette and Emile Raimbaud, Marie-Ange and Jacques Gendrot, Sapir, and myself. The conversation run about the review of Balint's famous book (*The Doctor, His Patient and the Illness*, 1957), just published in French.

Seizing the opportunity of a moment of silence, Jacques Gendrot addressed a question to Balint: "Please sir, why in your book you always talk about the Psychiatrist and not the Psychoanalyst as the leader of the group; after all, your reference is not psychiatry but actually psychoanalysis." A long and uneasy silence followed, and it was Mrs. Balint who broke it, saying something like: "Since my husband does not answer, I will give an answer: the fact is that my husband does not really like psychoanalysts." Balint added approvingly: "But after all, I have the perfect right to have an unconscious, and as you know, my father was a general practitioner." Soon after this exchange we came back to the settling of the business affairs of the fledgling Balint movement.

Everybody can go on thinking about the implications of this anecdote. As for me, I kept the feeling that this short dialogue touched something essential, that is, that Balint was principally interested in analyzing the doc-

tor–patient relationship. He always tried to go further in the study of this relationship, putting first something essential: the relationship of the human being with medicine and with illness. Above all, in the Balint groups we are concerned with the scientific aspects of illnesses, the doctor's and patient's reactions to well tested treatments.

Pierre Benoît

Catherine Reverzy is a child psychiatrist and psychoanalyst. She reports here how she encountered Balint's theories.

MEETING MICHAEL BALINT

I met Michael Balint one day when I was browsing in a bookstore. It must have been in 1978. I had just finished my training as a child psychiatrist and was practicing psychotherapy involving the body in a hospital center for teachers with emotional difficulties. At that time, Balint's name was connected to group work, and I had no knowledge of his work on objects relations.

Balint's picture on the cover of the French translation of *Basic Fault* caught my attention. His smile was warm and magnetic, one of an open mind. Reading his book confirmed my intuition. I was taken in by Balint's clear style, and as I read the book I immediately plunged into the primary world of affective relations. Balint's sense of humor and profound benevolence toward patients came through loud and clear. I was also reassured by his flexible point of view, especially regarding the necessity of maintaining different schools of thought to cover the various needs of the clinician. I was also taken in by his modesty as a true searcher, as he would say: "We are still so ignorant!"

Michael Balint contributed to bringing me closer to psychoanalysis at a time when my interests and choices were taking me toward humanistic therapies. I progressed in reading him with astonishing ease in understanding. At last, I, a beginner, had access to a theory that corresponded to some aspects of my empirical practice during those years. For example, on accompanying patients in crisis situations without interrupting the therapeutic process, Balint would accept to feel like "sand and water," enabling the dyad to work through the experience at a later moment.

More recently, Michael Balint and Sándor Ferenczi were both my company in my work with teachers who had been victims of physical aggressions, who had lost face in front of their students, and as a consequence, struggled with narcissistic wounds. Balint helped me to find a distance in

these stressful situations by showing me how to return to the analytic setting.

I also discovered this wonderful essay, "Thrills and Regression," where Balint, with considerable originality, explores the components of physical risk taking and search of thrills at a time when open air sports were beginning to develop. From his point of view, those games that include fright, pleasure, and an optimistic hope to be safe, same as the Freudian Fort-Da play, seen in circus shows and fairs "from San Francisco to Bombay and from Alaska to New-Zeeland," already existed in the antic world. Those components were moods of *philobatic* and *ocnophilic* object relating, two words he wished to introduce in the theory, after he had taken the advice of a philologist! Why two new words? Only they could describe what he tried to point out in primary object relating: two ways of loving and being in the world and concerning a lot of life situations. I must admit that his proposition of how we find closeness and comfortable distance with others, society, theories, and institutions enchanted me. Balint gives the amusing example of Hillary's conquest of Mont Everest in 1953. We know that Queen Elizabeth ennobled the New Zealander alpinist for his feat. But was it possible to refuse such an honor? Balint mentions as well how philobatic navigators are in such a bad mood as soon as they have reached their port, already dreaming about their next trip. Thrills and regression has also inspired my work on the sense of adventure and bravery of women in extreme, dangerous situations, an essay that I am writing for the public at the moment, twenty years after I read "Thrills and Regression."

The work of Balint has above all brought me to the important discoveries of Sándor Ferenczi and the Budapest School of Psychoanalysis and built my network of professional interests and affinities around this movement. I published the first medical thesis to be written on Ferenczi's work, in Geneva (1985), under the direction of Professor. Andre Haynal. I studied some of Ferenczi's main concerns as a medical doctor and psychiatrist, his social involvement, the desire to cure, the priority given to the clinic experience, the study of countertransference, the interest in the child as a victim of trauma, and his intuition about the therapeutic process of regression. These are some of the main themes throughout Ferenczi's writings, and we find them again in the work of Balint. I tried underline how Balint took Ferenczi's intuition concerning the growth potential in regression and theorized its therapeutic effects, especially concerning Ferenczi's *Thalassa*, as Balint spoke about the "regressive thalassic thrust." Since Balint's publications it is no longer possible to consider *Thalassa* as a separate part of Ferenczi's work but rather consider it as a central aspect of it.

To conclude, Balint's work is like a geographical map for me, offering

solid and elastic landmarks, allowing me to find my orientation in the land of psychoanalysis. Later on, I discovered by chance that a member of the Budapest school had trained one of my analysts, and I am very happy to think that I kept this link alive.

(Translation: Kathleen Kelley-Lainè and Judith Kovacs.)

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Bernard Suied is a pediatrist who attended a Balint group for years. He tells here what he gained from this participation.

FROM HOSPITAL PEDIATRICS TO A BALINT GROUP: THE STORY OF A JOURNEY

It all started in the hospital, in a group. My job as an extern, intern, and senior registrar was very gratifying: the presentation of the patients was rigorous, the observations were perfectly described and worded, and approved by the hospital staff headquarters: signs, diagnosis, treatments. The reassurance brought by group practice (a group, already!) suggested that the job was done properly and gave the illusion that one was all powerful. Nothing seemed to weaken this power: neither the cases of patients sent to hospital for nothing nor the symptoms occurring without organic explanation (and cleverly labeled functional, an easy word enabling doctors to do away with a problem and censor a symptom). Besides, this abdication in face of a symptom was granted amnesty by a few aphorisms: If you have the faintest doubt, make a lumbar puncture, just in case. If you suspect a case of appendicitis, however unlikely, a blank laparotomy is better than guilty abstaining. Any acute febrile pain in a knee must be treated as osteomyelitis until evidence is found to the contrary, and so on. There were references to vaguely similar cases: "You have to be really careful with fainting, even if it is short and ordinary. Once I found a pancreatic tumor in an older child," or "Once I treated a child who only had a slightly phlegmy cough, with diarrhea, in fact he suffered from mucoviscidosis." Nobody cared about the personal and medical background of patient or nursing staff.

What shall we say of the excess diagnoses given to doctors, or doctors' children, treated—often on the phone—by colleagues, friends, or relatives?

Am I exposing the excesses of resorting to the technical set in an unfair, archaic, and dangerous way? Certainly not. All I say is that in an emergency, the doctor is often alone, on duty, facing intense parental pressure,

alone with the risk of missing the disease. After the emergency, however, the doctor could, and should assess the problem with the general practitioner and the hospital staff. The presenting dysfunction may be due to the history and the demand of the parents (their personal and medical history) or the history of the nursing staff (house doctors or general practitioners), the conditions, and time of the consultation.

Again, without calling into question the dogmas and protocols of medical and postmedical training, I think that the doctor–patient relationship must also be taught because it is an important part of the medical art. Teaching the dynamics of the doctor–patient relationship might improve the results of our medical approach in terms of medical outcomes (and perhaps money), and it might explain some diagnostic wanderings, possibly even some diagnostic mistakes, the latter being more often caused by a misunderstanding, a mishearing than by medical incompetence.

The Doctor–Family Relationship

This relationship appeared to me as even more important when I set up as a pediatrician in an office in town, alone in the consulting room. There I discovered that those rare illnesses and fascinating cases, not to be neglected of course, represented only a tiny part of my practice. In my consulting room I was to treat ordinary symptoms, even if they appeared negligible to me, because they disturbed and worried the family.

When was I taught to do so? Who taught me the meaning of essential cephalalgia, recurring abdominal pain (without organic anomaly), or the cases or enuresis, twitches, sleep trouble, abnormal behavior at home or at school, when nothing has been found? How can we help and understand overprotective or abdicating parents? How can we answer—or not answer—the fundamental questions they ask after a routine consultation on their way out of the office? "I just wanted to tell you, doctor, that her father is not her real father?" "What can I say to my daughter who is ill?" Or, "Is it really a problem if my son sleeps in my bed and his father in the sitting-room, because he comes home late?" "My daughter has been speaking a lot about death lately, she can't sleep, she eats compulsively, or does not eat anything."

"The role of the paediatrician is to prevent mental illness, if only he knew it." Thus spoke Winnicott, a pediatrician who became an analyst. Is it true? Are we ready; are we prepared for the task? We are not. Academic teaching and later training do not teach us that kind of competence. This is why I felt that I had to take into account the history of the family as well, its dysfunctions, the symbolic place of each of its member, in short a more global assessment in my practice, all the more important as we occupy a

privileged place to shoulder the role of family doctor. I wanted to do this without losing sight of the fact that our mission still remains medical care, vaccination, nutrition advice, supervision of the size, weight, and psychomotor development of the child, curing diseases, detecting threatening illnesses, and so forth.

Did I Join a Balint Group Because of This Goal?

Not immediately. I first felt the need to know more about the development of the child and its possible difficulties, so I attended seminars, courses, study groups concerned with pediatric psychiatry. This definitely enlarged my training and enabled me to learn a new language.

And yet, the self-satisfaction that resulted from working with true professionals of the psyche, the psychiatrists, remained theoretical, or, at least, stranger to my daily practice. It flattered my narcissism, but if I was less bored, I did remain just as anxious. What is worse, I thought I was able to find an answer to all the questions asked by the family, and I flung back in their faces other questions or truths that the families were not ready to hear. I was not trained to listening to patients. I did not keep the right distance. I had not taken into account the tranference, the countertranference and all that the Statue of the Commander (my master's at the hospital) had engraved in my way of practicing. I was aware of these difficulties and was reassured by the fact that I shared them with my colleagues, as I joined a Balint group, after a personal psychoanalysis.

What Conclusions Can I Draw After 15 Years in a Balint Group?

I have undoubtedly broken my loneliness and improved the comfort of my consultations. I go on learning and listening better. Is this already the "limited but considerable change" described by Balint? The meetings between nursing staff, pediatrician, and a psychoanalyst as leader gradually emphasize the importance of the doctor–patient relationship, and of listening. Learning how to listen is certainly the most important thing that was facilitated by Balint's reflection: listening to the child who warns of a personal or family dysfunction, to the child as symptom, to the child burdened with a mission or with a question. Listening to the mother and/or the father, who speaks for both parents, or instead of the child, or just to cover the other one's speech. Listening to the nursing staff in his or her positive or negative relationship to that family. Why do I find them competent or incompetent, nice or unpleasant? Why do I fail to understand what they think and what they ask? What aspect of my own history (personal or professional), or their own history, interferes with the consultation at the office?

In conclusion, these sessions represent, and re-present, a training that no reading and no teaching could replace. Moreover, the co-piloting by a general practitioner and a psychoanalyst enables the group to decide safely on what looks serious or not in a symptom. In doubtful cases, it may be necessary to hand over the case for further medical assessment, resort to paraclinical tests, or to a medical expert, or to a psychotherapist if the history of the case seems too burdensome. Joining one of these groups requires, as can easily imagined, a personal involvement without censorship, judgment, or lying. In short, it requires tolerance of others and self.

(Translation: Henriette Michaud.)

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