# THE IMPORTANCE OF THE BODY IN BALINT WORK. BALINT PSYCHODRAMA

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At a congress on the theme of tradition and innovation in Balint work, it seems appropriate to discuss the method created and developed by Anne Caïn[1]. Anne Caïn, a French psychoanalyst, started using this method already in 1973 by associating Balint's approach with psychoanalytic psychodrama. By reintroducing the body into the training of caregivers it would seem to us that she was addressing one of Michael and Enid Balint's major concerns. According to Michel Sapir[2], the Balint thought that Balint work could be distorted by emphasizing psychological aspects of the relationship with the patient to the detriment of the body.

Where do we stand today with the scope given to the body in our Balint work? Presenting our work from this angle leads us to further questioning. How are we as caregivers affected in our own bodies by our encounters with patients and their bodies? And how does the encounter with our patients and the group members affect us in our work as group leaders? Indeed, in all aspects of our professional lives, even in the visual self-effacement of the psychoanalyst, our bodies are involved. It is also the attention paid to what we feel within our bodies that guides us in the understanding of some aspects of countertransference.

The body as " a vital dimension of human reality,… upon which is anchored all psychic functioning", has been, nearly all through a great part of the 20th century, the great absentee and denied in many aspects of life, by much of Human Science as well as by the psychologism of many psychotherapists. Didier Anzieu who stated that in 1974 [3] reminded us too that in Freud's time the great absentee was sexuality. Undoubtedly things have changed since Anzieu's writings for many analysts though not for all. Without discussing the complex history of the body in psychoanalysis I would like to recall here a few basic points in the articulation of the body, its language, and memory.

At the beginning of his work the importance Freud gave to the body was indissociable from that of memory. "Hysterics suffer for the most part from reminiscences" wrote Breuer and Freud in *Studies on Hysteria*[4]. It was through the body and its various symptoms, transient or lasting, that psychic conflict was symbolically expressed. At its beginning, the psychoanalytic cure was effective through remembering. The lifting of repression, by working

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through traumatic memories, led to the symptom's disappearance. This approach soon showed its limits and Freud progressively stressed the importance of phantasy. Imaginary scenarios, as deformed as they may be, express our wish to satisfy our conscious and unconscious desires. Although some of them are primal phantasies, universal, preverbal and belong to our phylogenetic patrimony, phantasies are also a personal experience bound up in the subject's history and in the history of the encounters with others.

Freud came to realise that some patients are unable to revive memories, for some events have never become representations in their minds, let alone take the form of verbal language. Forgotten events reappear repeatedly. There is a compulsion to repeat not through words but through actions, by a way of being. In this way Freud introduced the notion of a non-mnemonic memory and proposed a more extensive comprehension of language. "« Language must be understood not merely to mean the expression of thought in words but to include the speech of gesture and every other method,…., by which mental activity can be expressed"[5]. Even if essential concepts of psychoanalysis are related to the body, i.e the Ego, the drives, and if Freud referred to this more extensive conception of language not only for hysteria but for obsessions[6], Freud attempted to eliminate or trivialize the somatic dimension, not only in his personal life, but in psychoanalytic training as well (Haynal[7]).

Freud completed his first model, based on removal of repression, and had recourse to the notions of construction and reconstruction.[8] This conception of the psychoanalytic approach which includes remembering, fantasies, construction and reconstruction, is the one to which Anne Caïn remained attached in her work as a psychoanalyst and as a psychodramatist.

Neither in Balint work nor in the Balint psychodrama method do we naïvely transpose essential or specific aspects of the analytic approach and process. Participants in our groups are not patients. They come with their difficulties of understanding their patients, with their fears of not being able to contain their feelings and cope with their emotions, and sometimes too with the awareness of repeating unsatisfactory patterns in their professional lives. The specificity of our work is focused on a psychoanalytic understanding of the relationship between caregivers and patients, of the professional identity of caregivers, of their wishes, or of whatever conscious or unconscious conflicts that may arise in this context.

The body was of great importance to Michael Balint in his work as a psychoanalyst. He privileged (and in this he is a follower of Ferenczi) the path of experience. In his study on regression[9] he shows how, in the psychoanalytic situation, objective and detached factual descriptions are not sufficient for the patient. Concomitant emotions will have to be expressed as well. And it is through body language, through the varying intensity and pitch of voice, through gestures or movements, or even having recourse to actions, that the patient

demonstrates this. Acting-out was as important to Balint as were free associations. Actings were understood by him not only as repetition but also sometimes as moments of creative value in favour of change towards a "new beginning". Balint even occasionally described the acting-in as a true psychic breakthrough, as we sometimes observe it in Balint psychodrama sessions.

The body of which we speak in Balint work is perhaps not the same as the one generally referred to in the field of psychoanalysis. In Balint work we may regard the body as the bearer of the subject's history and also as a bearer of messages[10]. Contrary to the psychoanalytic approach it does not intentionally investigate the specific unconscious body image[11] or that of the body as an internal object[12].

When Balint and the members of his first group realised that attempting to adapt new techniques imported from psychiatry was unsatisfactory, they changed their attitude (Trenkel[13]). They centered their work on the specific interactions between doctor and patient and examined to what extent these transactions could themselves harbour greater potential for diagnosis and therapy. This change of attitude was, according to A. Trenkel, a psychic breakthrough. So the relational viewpoint does not only open larger perspectives in the psychic sphere but also with regard to the body as a participant in the relationship.

Even if it was only fully understood in hindsight, Balint psychodrama appears to be mainly concerned with the reintroduction of the body and the involvement of bodily experience in the training of caregivers. The mobilization of the body enhances a process that is however already present, though mostly silently present, in every Balint group.

Anne Caïn used to say that the body does not lie. She considered that it recorded its own past. "The body carries with it the trace of the subject's personal history". Working in Balint psychodrama is attempting to get to the roots of this singular past while remaining within the strict limits of the professional sphere of the encounter with the patient and with his body. Those who worked with Anne Caïn know all the care she took with the presenter of the case to retrieve many historical aspects of the relationship, even those preceding the first meeting. She explored the relation of the caregiver to his workplace, to his environment and to the representation he may have of his future patient. Her intention was to facilitate the process of remembering, thus enabling to discover the premises of countertransference. Very often countertransference precedes transference.

In Balint psychodrama the group leader focuses on verbalizations about the body. He also pays particular attention to the body language of all those present, including the presenter and other group members, as well as to the sensations he himself experiences. But these aspects can evidently not be dissociated from other elements that organise different language

forms within the group: phenomena of transference, phantasies that organise the group, the meaning of the succession of the cases presented, etc.

**Let us take an example of a group session.**

*Dr Marie A. has known Madeleine for eighteen years. Madeleine was her neighbour for many years. She shared with her and her family common interests in an association before leaving to pursue a brilliant career in another city. Madeleine had been Dr A's patient and undoubtedly she considers her former doctor to be a friend. They use familiar language form and Madeleine has a spontaneous tendency to want to kiss her doctor when she comes to revisit her. Anyway this is what we gather when she is asked to play during the first scene. Dr A meets her patient. But in the scene, as in reality, Dr A. avoids this gesture, shies away form doing it. Madeleine has returned to their city as a result of burn-out which she has come back to cure. She has chosen during her sick-leave to be treated once again by Dr A.*

*Through various scenes we discover certain elements of this relationship which is naturally complex because of the intertwining of personal and professional links between them. Dr A appears very rigorous, concerned, active and organized. She shows us all the care she takes to bring to Madeleine's attention the full measure of her fatigue and for her to realize that her suffering cannot be resolved through a unique rational explanation: diagnosing burn-out. How can Madeleine be helped to take care also of her body, not to seek refuge in denial and in flight? How can Dr A. stop her from seeking a miracle remedy through different kinds of therapies? Dr A. is very at ease with the Balint method of psychodrama. She lays the décor and often takes it upon herself to initiate rapid role changes. I observe a well orchestrated ballet which brings out in me a feeling of fatigue as well as a moment of great sadness. When during an exchange of roles Dr A wants to play the part of Madeleine, so defensive, so fatigued, sitting opposite her, she reaches her arm out very delicately to touch Madeleine on the arm as she rises from her seat. Following this scene the participant who played Madeleine's part says how touched she was by Dr A's gesture. Did Dr A really make this gesture during the consultation? No, it was only made during the scene as a participant. This spontaneous gesture took on a great value for me. It seemed to me to reveal a closeness that Dr A forbade herself, an empathy that in the singularity of their encounter had not up till then been able to take place. I thought that Madeleine had revealed to Dr A a representation of herself that she tried to brush aside, and to distance herself from. This partly unconscious mirror image of herself made her role as a doctor very painful.*

*The next scene, when strong emotion arises as Dr A gets ready to examine her patient's belly, prolongs the transformational process she experiences during the session. The leader stops the scene when Dr A says she is going to start crying.*

I centered my brief description of this session on two types of languages: the language of affects, and the body language or the language of the act, but of course, like in every Balint work the language of words predominate.

The reconstruction of scenes that caregivers retrieve from their working lives have to be as faithful as possible to what happened in the reality of the encounter. However they bear the stamps of deferred effect (concept of *Nachträglichkeit*). The body's mobilization allows, as in any psychodramatic work, the re-emergence of motor memory, not only of repressed memory, that has long been buried. In this way the affect is rekindled with its binding effect to representations. This is an important part of our work insofar as it may open the way to working through issues that concern all members of the group. It is often when there is an exchange of roles, the most frequently used technique in Balint psychodrama, when the caregiver plays the part of his patient, that there is verbal and bodily expression of an important aspect of the problematic brought to the group by the presenter.

The dubbing, the soliloquies that accompany all acting take part in the process of free associations. These subsidiary actions promote personal and group phantasies. The purpose is obviously not to concentrate on the presenter's bodily responses but rather to integrate them into a shared emotional event experienced by the entire group and subject to rational understanding.

The study of the therapist's countertransference seems to us regularly encouraged by the acting since acting promotes processes of identification. Playing the part of the carer as well as that of the patient brings to life, sustains and facilitates identificatory phenomena that are the foundation of all emotional understanding. Even if the accent is laid here on the carer's bodily mobilization, and on the possibility of finding or retrieving feelings and experiences that are part of his countertransferance, Balint psychodrama does not encourage conscious verbalizations about the body or about body language. It rather enriches preconscious psychic processes that characterize every groupwork.

What Michael and Enid Balint'[14] wrote resounds extremely meaningfully with a Balint psychodrama leader: "the observer must be in tune to such an extent that for a brief time, perhaps only for a few moments, he may feel as if he were himself the person observed or the creator of the object under observation.… No identification is possible unless the observer is

prepared to have new experiences and wishes, or even expects to learn something that may be alien and even alarming to him". The caregiver's tentative identification with his rediscovered and "recreated" patient alternate with retreat to objectivity. These identifications are mediated by the patient's body and his symptoms. They are also manifested by the therapist's own body and by his body language.

Recent advances in neurosciences and in the role of mirror neurons may help us to complete our understanding of the complex mechanisms that intervene in our work. I refer here especially to the concept of embodied simulation described by Vittorio Gallese[15].

As group leaders of Balint psychodrama we are aware that the method we use seems or has seemed surprising, even strange, to some of our colleagues. I hope that my talk has enabled you to come closer to an understanding of our work. We enjoy our work as group leaders and we would like to share this interest and pleasure with you. For some this sharing will occur in the group experience but for all of us it will be present in our discussions and exchanges here at this congress.

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[2] Michel Sapir (1982) in : André Missenard. L'expérience Balint. Histoire et actualité. Dunod, Paris.
[3] Didier Anzieu (1995). Le Moi-Peau, Dunod, Paris.p 43.
[4] J. Breuer et S. Freud (1895). Le mécanisme psychique des phénomènes hystériques. Chapitre I. Etudes sur l'hystérie. PUF, p 5. Standard Edition. Studies on Hysteria. Vol II.
[5] S. Freud. (1913). L'intérêt de la psychanalyse, in : Résultats, idées. Problèmes I, 1890-1920. PUF, Paris,1991. pp186-213. Standard Edition, Vol XIII: " Scientific Interest in Psycho-Analysis. 1913. The claims of psycho-analysis to the interest of the non-psychological sciences. The philological interest of psycho-analysis. P 176.
[6] S. Freud (1907) : "Zwangshandlungen und Religionsübungen". Actions compulsionnelles et actes religieux, in : Névrose, Psychose, Perversion, PUF.
[7] André Haynal (2008) Freud, His Illness, and Ourselves, The American Journal of Psychoanalysis, vol. 68 n°2: 103-116.
[8] S. Freud, (1937). Constructions dans l'analyse. In : Résultats, Idées, Problèmes, tome II, PUF, Paris. Construction in analysis. Standard Edition. Vol. XXIII, 257-269. "Quite often, Freud says, we do not succeed in bringing the patient to recollect what has been repressed. Instead of that, if the analysis is carried on correctly, we produce in him an assured conviction of the truth of the construction which achieves the same therapeutic result as recaptured memory".
[9] Michael Balint (1969) . The Basic Fault, Therapeutic aspects of regression. Tavistock Publications , London. Chap 14.
[10] René Roussillon (2006). Corps et actes messagers. Colloque Lyon2 du CRPPC.
[11] «By body image we mean the mental representation we have of our own body, the image that the person little by little makes of himself. It includes fantasies and particularly subconscious fantasies into which the external world also intervenes." Daniel Rosenfield (2005). Image du corps. In : Alain de Mijolla. Dictionnaire international de la psychanalyse. Hachette , Paris.
[12] Eglée Laufer Moses (2005) differentiates between the body image made up of sensorial experiences and the erotic body which is an aspect of what she calls the body's relation to the internal object. The erotic body (internal) has qualities that are both good and bad and that depend on the emotional experiences with primary objects and specific parts of the body. Le corps comme objet interne In: Adolescence. Vol 52.
[13] Arthur Trenkel (1989), In Michel Sapir: Formation à la relation soignant / soigné. La Pensée Sauvage. Grenoble.
[14] Michael Balint, Enid Balint (1961). Psychotherapeutic Techniques in Medicine. Tavistock Publications, London.
[15] V. Gallese (2008): *Empathy, Embodied Simulation and the Brain.* J. Am. Psychoanalytic Association. Vol 56 : 769.