Monosymptomatic groups with anorexic and boulimic patients and basic assumptions: the somatic dimension in these patients and the position of the analyst

Francesco Comelli

Abstract
It is important to reflect upon Bion's concepts about the basic group, as these groups are more and more growing. Many of them are centred and formed upon a symptomatology in which the somatic dimension is an important part in the subject disease entering the group. I believe that the first Bion purpose (1), -concerning his reflections upon basic assumptions - was to give a method and not only a theory to be tested and applied working with groups.

Key words: group, anorexic and boulimic patients, position of the analyst, basic assumption,

With recent contributions on field theory (2, 3, 4, 5), these Bion's reflections have not yet explained the role of the group analyst, who is not out of the group, but concerned in a emotional relation with the group.
Our position of group leaders has centred the attention upon our experience in this relation with the group and its specificy. In this case an anorexic and boulimic group.
This lets me explain my personnel reflection upon the monosymptomatic group trying to understand it not as an external object, but from the inside.
It is important to define the field in which we work and are changed.
First of all it is important to understand if there is a difference in working with a monosymptomatic group in relation to a classic heterosymptomatic even if I do not want to create new spaces in which to box different groups.
I want to reflect upon basic assumptions and protomental system in a defined group by its pathology and somatic involvement. It is of course impossible to how many variables there are at the birth of a group. I want to ask myself and understand which founding elements are already present in the anorexic group.
The group formed by anorexic and boulimic patients, even before its living marks the analyst position.
It is possibile also that this analyst would present inconsciously a characteristic inconscious relations.
We should ask too if it is different to operate with psycothic or anorexic patients. Should the analyst bear in himself some specific symptomatic expression?
If it is so, why?
I will try to give an answer, facing the relation between the body and the group.

Bion already reflected upon monosymptomatic stage; he wondered why subjects, with the same pathology, tend to gather. He referred about tubercolotic patients (1). He could observe the patients working in a sanatory.
As we all know, Bion speaks upon basic assumptions of the group, starting from groups, gathered by a common pathology, as emotional common inconscious states of the group, which undestands a certain fact according to a primitive code, instead of a more rational and conscious thinking, called work group.
If a basic assumptions is active, the two others would be in a protomental stage, in there is not difference between physical and psychical. According to Bion, the basic assumptions, the primitive emotions of the group, are of the depending type: pairing and fight and flight;
He thought that a pathology with common physical manifestation should relate both to the individual and the group. That is that a psychological part of the group would exist, in relation to the emotions of the group.
Who works in a hospital knows how it is clear that people with the same disease express mutual values: it is common to observe drug addicts as homogeneous, but it is the same – for instance - in patients with somatic or psycosomatic symptoms as in patients suffering ulcerous colitis. Being tuberculotic, according to Bion, is accompanied by a depending basic assumption. This refers to the emotions or shapes of the group.
But if it is true that a pathology has a corresponding emotion in the group, it is also true that the same pathology is susceptible to group psychology.
In metapsychological terms, working on basic assumptions of the monosymptomatic group can be a non symptomatic remedy, with curative parts for the diseases we treat.
Let us imagine, as in mathematics we have a not known value and a known value , that the not known value be anorexia, and that the known value be that to become anorexic means to transform a own position related to a group: let's imagine thus , as a specific hypothesys, that to become anorexic means to change from a depending position by a group (for example by the family, by a member representing the family or by a tansgenerational line of the family), to a fight flight position related to the same family group.
We can go further thinking that these positions are referred not only to the individual position of the patients towards a parental individual, but also to the relation between the patients and their parents as group. So we could pass through a depending position to a fight-opposition position.
We should always consider the individual story of the patient, also in relation with the group, in which she express herself.
If this is true, the monosymptomatic group should be represented as a position of fight and flight. Patients should already have a group position when they enter the group, with many implications about the therapist. First their position seems to be homogeneous in their relation with a certain kind of family.
This uniformity corresponds both to their reflection and a natural gathering of people which are already inconsciously identified, on the basis of a collective emotion of

opposition to a group. If the monosymptomatic group expresses a basic mentality, for instance of fight and flight, the leader should wonder which position to take and how to treat this basic assumption. This should be gathered and completed with the rational part of the group; that means that the therapist shall not be surprised by this attack. That's why usually forced maternages fail as they cannot represent the opposition and the fight that patients feel in the emotions of the group.

Many health institutions care about nutritional aspects of patients with alimentary disorders without understanding the value of the message that the anorexic patient seems to bring.

If anorexic and boulimic patients are in a position that needs to express opposition in relation to a group, it seems comprehensible that they cannot develop therapeutic relations in presence of a strong protective position, avoiding their emotional need of opposition.

I would reflect upon the gap between our caring role in the group and the need of the patients to express an emotional positions of fight, opposition, refusal, which can be compared to the cases of a basic group.

The anorexic would express a need to spread out of the family, especially with symptoms and with the body, without a conscious process of separation, but also a pathological attachment.

I would use the image of breast: if an anorexic patient refuses breast, we will expect that she refuses it also during her analysis. We know that the tolerance of the absence of breast is important in the development of psychopathological forms.

If the tolerance (6) and then the distance from breast lets the subject to represent it with the thought; the untolerance will perform an important evacuation of projections, through the perceptive system, which ejects instead of receiving, as during hallucinations. I think that if the anorexic patient seems to become – in a pre-symptomatological moment, herlself the breast which feeds parents, this means that the own perception would be after gratifying needs of others.

The absence of the breast should be avoided thanks to a mechanism of primary identification, that is a reversal of the role infant-parent. In this case, the infant should feed the parent; this should bring to a progressive disappearence of pleasure, as it brings the subject far from the perception of his own need. According to Freud (7), the instinct of surveying which pushes the infant to reach and feed through the breast; lays on its pulsional satisfaction, tied to its orality and to the maternal pleasure of feeding, according to a libidic position of a nutritional parent and a receiving child;

The fuction of the anorexic patients, who do not feed themselves, feeding symbolically their own parent, seems to be a way of sustaining in their family powerful dyamics.

This hypothesis suggests the presence of a precox ego, who cannot imagine a naughty mummy, saving however the other.

This position would fit with a following reduction of all the pulsional and objectual satisfaction of the subject. Without the pulsional satisfaction, the only instinct cannot

let the subject survey. The role of the pleasure of the subject will fade when the subject cancels its own pulsional questions, for the benefit of the other.
Many of the anamnesis of anorexic patients identify daughters taking care of mothers as children: So the daugher becomes parent of her parents (one or both).
It is very important to gaze both at the familiar group, as at the anamnesis, in relation to the patient's stories in her relation with the family as a group, even in different generations.
According to this hypothesis, the opposition that the anorexic patient can express with somatic sympton of slimming, reflects the need of keeping far the family.
The implications would be the following three:

1. the projective identification of the anorexic-boulimic patients would not be mainly represented by evacuations of primitive emotions or strange objects, but by the projection of emptiness and non-tie. The position of the psychoanalyst is in the wholeness of the group only if it is possible to live actvily the non-tie and the emptiness; giving voice to his own analitic subjectivity;
2. Patients do express fright in ties and pleasure, even if they need strongly, as the pleasure and the satisfaction in relations break the balance that the anorexic subject finds frozing her own needs feeding another one.
3. The basic assumption of fight and flight in anorexia could not be expressed psychologically but especially with the soma, in its symptomatic phase; thus it shall be read and shown; This transformation in a subject would correspond to the passage from the basic assumption as object to the rational work group.

The monosymptomatic group can be said to have a strong identity, built by the counterpart of the expression with somatic parts of the basic assumption of fight and flight which waits for a thinking function managing to represent mentally and verbally the opposition in order to transfom in a subjectivation; thhroug a passage to a work group.
If the message fo the patients is shown trough the soma, tha analyst too would be related (the somatic countertransfert) (8).
So, the group sould extend to the analyst the fact of being himself a body without using the mind, removing a subjectivation which can be expressed by being the sensitive organ of the group;
These hypothesis are valid if related to nevrotic anorexia as the psychotic needs different techniques and pathology that I will not explain in this occasion.
In anoher work (9) I presented some clinical exemples to sustain this hypothesis.
However the clynical reflection of these thoughts comes from a group in which I remember how positively strong was perceived my active being, felt as need to rise a function of contact and care of patients. One patient remembered how it was important for her to be sent to a community and for this she will thank for ever whom has pushed her to enter the community, speaking about "bombing"; The patient referred – in this cas – to the stimulating function linked to the strong mutual skill in a group. In the same seat another patient (a doctor) remembered with anxiety the role of the psycotherapist which stood still smoking and waiting; She remembered only

this waiting and the emptiness corresponding to her continouos chatting, without relation and without an answer; The group spoke about this positive emotional bombing, pointing out the correponsability of the grou upon single subjects.
Joyce Mc Dougall (10) says that cases in which the expression of emotions and feelings is poor and inside the proper psychological disease, the subjectivity of the analyst gets more and more important for the patient: in a group this means that the analyst and the group should feel what the mind of the anlyst develops in contact with the group itself;
If the subjective experience of the analyst of group is formed by parts which represent the emotional experience of the patients; we can understand how it cannot be avoided or misunderstood.
As a matter of fact the analytic functions is often linked – when possible – to the attempt of traslating a thought based upon the communication mother-child, which appear through the projective identification.
According to this hypothesis of reversal of the role mother-child, relating to the anorexic patient, with the following attempt of gather the projective identification instead of evacuating, the analiyst should face this implosion without becoming not only a receiving parent, passive, fed by the patients. The analyst should observe what is missing, more that observing what is kept inside. I found very different the emotional colonization due to a strong projection capable of activating quick answer from the analyst, as in schizophrenic psychosis in their acute phase, in relating to the anestetic emptiness of the relation; due to the projective implosion.
The psychotic who communicates verbally his intention of a physical attack will bring a block and respect of distance: he projects in the analyst strong feelins upon anxieties, for instance a strong fear, which we experiment immediately. He makes us scared or however respecting his space or again to treat our own fear to give him back a lesser fear.
The projective implosion brings the analyst to feel what is missing more than its content; So the analyst is not a container but a co-producer of the group container.
In relationd with this emptiness, the analyst needs to listen actively to the noise that the emptiness will produce inside, giving voice to not yet thought and seen forms, generating an emptiness of meanings rather than an obliterating emptiness;
The difference between the analyst and the patients is that the analyst does not leave from a total emptiness, as he has experiences, due to long analysis and/or the work of shared reflection which he carris on daily.
It is important to experiment upon us ourselves and upon the group what we feel and clinically think in order to confirm collectively what we feel to a hypothetic level.
The reflections upon my work can represent a hypoothesis, which I can live in contact with the group and this gives me a feeling of tie with a thought and the thought of my collegues.
In this case the analyst swings between being parte of a group of collegues and sharing the group of the patients; The gap between these two experiences seems to me an experience both for the patients and the analyst.

We should ask about the internal group of the analyst as mean to relate with the collegues, with the patients and with the position of the anlyst himself.

References

1 Bion, W.R. – E*xperiences in groups and other papers*- Tavistock publications LTD 1961.
2 Gaburri E.- *Emozione e interpretazione*- Torino: Bollati Boringhieri ed 1997.
3 Rugi G.- *Il campo gruppale*. Roma: Borla, 1998.
4 Baranger W.; Baranger M. (acura di) *La situazione psicoanalitica come campo bipersonale*- Cortina ed. 1969 Milano
5 Neri C.- Commutare- commuovere. Transiti dal gruppo all' individuo e viceversa. In: Gaburri E. - *Emozione e interpretazione*- Torino: Bollati Boringhieri ed 1997.
6 Bion W.R.- A*nalisi degli schizofrenici e metodo psicoanalitico*- Armando ed. 1996.
7 Freud S.- *Pulsioni e loro destini*- vol 8 OSF; Torino. Bollati Boringhieri ed 1995.
8 Galli A., Gammaro Moroni P. - Centro Milanese di psicoanalisi- 9 maggio 2002; Relazione sul lavoro del gruppo di studio:"LA QUESTIONE PSICOSOMATICA: CORPO, FANTASIA INCONSCIA, PENSIERO E LINGUAGGIO".
9 Comellli F. Dialoghi intorno all' essere analisti in realzione al gruppo. In: Speranza (a cura di)- *La posizione dell' analista nel gruppo*- Milano: Franco Angeli ed. (in corso di pubblicazione)
10 Mc Dougall J. (1996), *Teatri del corpo*. Milano: Cortina ed. 1996.

Francesco Comelli is Psychiatrist, Psychoanalyst (SPI) and Group Psychoanalyst (IIPG). *Medical (sanitario)* Director of the ABA (Ass. for the Research and care of the Anorexia/Bulimia) in Milan. He is consulting (consulente) psychiatrist at some Therapeutic Communities.
E-mail: francesco.comelli@alice.it