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The Body Speaks: Bion's Protomental System at Work1

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Psychoanalysis has primarily explored somatic experience in relation to love and intimacy. This paper focuses on the body in relation to work. It explores the experience that what patients increasingly present for analysis are the traumas and pleasures of being caught up with and belonging to a body larger than their own, whether in a couple, a group, a work organization or the body politic. It begins with an exploration of Bion's idea of a relationship between protomentality and group disease. It goes on to consider what can be conceived of as his ecological methodology, which enables movement between different 'fields of study' (Bion 1962). These are applied to the health risks encountered by psychotherapists and the profession as a whole. Finally, there is a proposal for mentoring to address professional health, as an under-developed element in the profession.

> *The ego is first and foremost a bodily ego.*
>
> *(Freud 1927)*

Bion's Protomental System

Chapter 5 of Bion's *Experiences in Groups*[2] (Bion 1962) forms part of the background[3] to this paper. It outlines his idea of the *protomental* matrix. This is generally less well known than his idea of the need for containment to transform sense experience (*beta-elements*) into emotional experience that can be symbolized and thought about (*alpha-function*), and that can be explored through the various permutations of the relationship between *container-contained* ♂♀ (Bion 1963).

Bion conceived the protomental 'as one in which physical and psychological are undifferentiated' (Bion 1962, p. 104), and in which there is:

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> *[the] difficulty that attends any attempt at determination of the line that separates psychological from physical phenomena. I propose therefore to leave indeterminate the limits that separate the active basic assumption from those I have relegated to the ... protomental system. (Bion 1962, p. 154)*

Bion's Ecological Method

The next important idea in Chapter 5 of *Experiences in Groups* was Bion's methodology of shifting the *field of study*, as he puts it. His methodology is best understood by reference to his later idea about emotional growth and development, namely that it takes place across a divide between contrasting experiences accompanied by *catastrophic anxiety* that he associates with the embodied experience of the *caesura* of birth (Bion 1989, 1991). This model of development is from one state of being and a containing environment: foetus in the womb, through the caesura of birth; to another state of being and containment: newborn dependent on the psycho-physical womb of mother's thoughtful care. Bion's methodology makes a series of similar moves in the *field of study*, each of which heralds his idea of *container-contained* ♂ ♀, with each dimension contained by belonging to a larger body.

In describing the nature of the *protomental* Bion writes:

> *The sphere of protomental events cannot be understood by reference to the individual alone, and the intelligible field of study for the dynamics of proto-mental events is the individuals met together in a group. (Bion 1962, p. 103)*

In describing the *protomental* matrix and its *basic assumptions* he was inspired by Freud's move from one person intra-psychic psychology to a two person relational psychology in exploring what is revealed about displaced hysterical symptoms in the transference relationship as it develops. Bion developed this idea of what could be called *relatedness* as a model to explore what might be revealed in the study of the individual's relationship to the group. This resulted in his *protomental* system with its *basic assumption* mentalities.

Bion then made a further shift in the focus of study to explore group diseases, which might be called *socio-somatics*:

> *It is these proto-mental levels that provide the matrix of group diseases. These diseases manifest themselves in the individual but they have characteristics that make it clear that it is the group rather than the individual that is stricken. (Bion 1962, p. 104)*

Using this idea of making shifts in the *field of study*, this paper explores whether the relationship between the individual psychosomatic body on the one hand, and larger corporal, or corporate bodies on the other, could be explored using the following step changes in the field of study:

Freud's idea that psychosomatic symptoms can be transformed by language and understanding of the transference relationship emerging between patient and therapist

A couple relationship that somatizes unthinkable trauma

A group where the group's disease is expressed in an individual's symptom

Occupational health where the work organization is getting under the skin of an individual

Stress illness and its epidemic social dynamics

Occupational health and safety risks endemic to those in the psychotherapy profession

Mentoring for psychoanalytic work

These step changes will now be explored in more detail.

Freud: From Hysterical Psychosomatics to the Transference Relationship

Freud's idea of hysteria can be understood as a case of referred pain. The original traumatizing experience is full of shame and guilt and so is unconsciously repressed, while the pain of it reappears in the caricature of the hysterical symptom or emotion that is displaced. In writing about the Paris school of psychosomatics, Aisenstein writes: 'Hysterical conversion makes the body into a language, the symptoms telling an unconscious story' (2006, p. 668). This insight is not new. In 1612, John Donne the English metaphysical poet wrote:

> *Her pure and eloquent blood*
>
> *Spoke in her cheeks, and so distinctly wrought,*
>
> *That one might almost say, her body thought. (Donne 1612)*

Perhaps the idea of using language as a means of social communication to contain the body was better put, in 1834, by Thomas Carlyle the Scottish philosopher:

> *Language is called the garment of thought: however,*
>
> *It should rather be, language is the flesh-garment,*
>
> *The body of thought. (Carlyle 1834)*

Our social language for emotional states is full of bodily metaphors: suck it and see, getting your teeth into a situation, really getting inside someone, biting off more than you can chew. These gut feelings can be seen as aspects of what Freud described as the transformation of infantile experience of preverbal oral, anal or genital experience of the body, working with the

pleasure principle to re-balance internal psycho-physical experience of pain and pleasure (Freud 1905).

Drawing again on the work of the Paris School of Psychosomatics Stora proposes a new development of Freud's thinking about the mind-body link:

> *It is no longer a question of psychosomatic diseases but the role that the psyche plays in all diseases without actually being their cause*

> *... The psyche participates in the defense of both the organism and the immune system ... (Stora 2007)*

He goes on to reveal that the cultural and social dimension provides the context in which such defences may be orchestrated.

McDougall and Brown among others introduce the term *alexythymia* to describe a lack of capacity to articulate emotions in words. This is found in families, cultures and social groups where such 'emotional-word-blindness' is perpetuated. McDougall associates this condition with the use of the body to express emotion that cannot be regulated by verbal expression. It is therefore often to be found as a feature of psychosomatic symptoms (Brown 2006; McDougall 1989, 1995).

Regression into the Body: Progression into Thoughtfulness: Giving Birth to New Ideas

People ordinarily regress in everyday life. The warm bath, the surrounding envelope of familiar music, the presence of a loved pet, the soothing touch of a familiar and safe person, all recall the sensuous nature of what can be imagined as intra-uterine experience. The capacity to make a bed comfortable, to fall asleep and take the risks of dreaming, belong to such regressions into the arms and bosom of sleep. The psychoanalyst's use of attention and the couch are shaped to facilitate a regression in the service not of pleasure, but of discovering what the ego needs to integrate (Balint 1968).

These regressions need attention and interpretation to be transformed into emotional experience that can be thought about. Winnicott emphasized how the mother's task was to protect the child from the experience of excessive excitations from inside and out until such time as the ego was able to integrate them (Winnicott 1965). It is part of the cornerstone of contemporary psychoanalytic work that this trauma of impingement at the preverbal level is retained in the body encapsulated and unsymbolized. Language has to be created through shared experience for the move from catastrophic expectation to articulation, before the work of thinking, grieving and integration can proceed (Mitrani 2008; Tustin 1981; Winnicott 1965).

When Bion describes the catastrophic risks involved in the *caesura* of birth, he can be understood to be describing resistance to the loss of equilibrium involved in change. In other words, the psyche establishes within itself defensive attachments to rigid patterns of relating in order to protect it from feared emotional overload if a new reality is conceived. The power of

this internal *establishment*, as Bion (1970) describes it, could be thought of as an internal, narcissistic and destructive defensive structure which attacks development. This is illustrated in Meltzer's description of a woman with a psychosomatic aspect to the timing of the failure of her immune system to combat an inherent cancer at a point of development in her life. Through a series of dreams and associations Meltzer describes the internal structuring of her early object relations with a punitive superego with violent intentions towards her repudiated infant self that needed help. This need became symptomatic through failure in the immune system to combat the cancer. Meltzer draws the parallel between the violent intentions towards the infant part of the self that was not allowed to develop and Bion's description of the basic assumption group whose leader (the internalized parent) demands to be placated; and yet the price of security through obedience, with its sacrifice of individuality, is hardly noticed (Meltzer 1986).

There are parallels with such internal defensive structures that have been analysed by Menzies Lyth (1959), initially in the nursing profession, in researching excessive use of bureaucracy in organizations to manage anxieties that threaten at work. She suggests that the compromise bureaucracy functioned as a defence against anxiety and yet, at the same time, prevented nurses from being more humane and flexible in their treatment of patients because they were subject to the inflexible establishment of rigid routines.

From Quantum of Psychic Energy into Thought: Behind Beta-Elements

Freud's genius was to perceive the mind's function of managing the quantum of internal and external psycho-physical excitations and to elaborate them through the work of dreams and self-expression. For Bion physical sensations provided the basic elements of experience. These are what people say they ‘feel in their bones’ or ‘on their skin’ as a way of describing sensation-based intuitions that have not yet taken shape. Such shapes provide premonitions of something that can eventually come to be known. For Bion this was the origin of the *protomental* system. This was his way of describing the way the mind experiences internal drives as sensations that have the capacity, if thought about, to represent a transformation from preconceptual knowledge to insight. He laid emphasis on premonitions to describe the intuitive apprehension that there might be something that the mind could get hold of by digesting it. This confirms the value in an observation, such as a countertransference impression, being what can be described as ‘food for thought’ (Billow 2003, p. 197; Bion 1963, p. 86).

Being able to do the mental digesting demands a mind that can do the thinking, either one's own or borrowing that of another for projective identification as a means of communication. Alternatively, where sensations or emotions are too painful to bear, Bion suggests that the individual seeks

membership of a group that will help with the need to suppress that emotion. It is the group mind that is recruited for support, because the group can express and legitimize an emotional framework. This it does either by supporting emotions where the individual mind cannot sustain them, or by helping to suppress them in the attempt to do away with them. He describes the attraction of an individual for a particular patterning of emotions in a group as *valency*, borrowing from chemistry a term to describe the way molecules are attracted to each other (Bion 1962). Later he develops this idea into the theory of *beta-elements*(Bion 1963), describing the mental work of transforming elements of experience into thought as *alpha-function.*

Basic Assumptions

Bion analyses the way groups appear to have a tacit set of common assumptions, shared unconsciously, that shape emotional experience. These appear to be determined by an instinctual fear of not surviving by not belonging. He calls these *basic assumptions* and suggests that they marginalize individual experience in a way that often makes group experience feel frightening, split off or psychotic to the individual member who sacrifices themselves to the group's culture. As one group member put it: ‘To belong to the group you have to give up being just you and jump in the deep end with the others’.

Bion, following Wilfred Trotter's (1916) work on the herd instinct, suggests three main *basic assumptions* that represent a group's need to belong (Torres 2003). He describes three sets that pattern the emotions of these implicitly shared assumptions:

dependency upon a leader or idea - this meets the survival need for nurture

pairing between two or more members of the group with the expectation of a new birth or beginning in which people can participate with curiosity or imitate - this meets the survival need for intimacy

fight/flight, the adrenalin response to threat in the face of a real or imagined enemy or otherness to the group - this provides the survival need of a boundary or skin to protect from outsiders perceived as dangerous

Each *basic assumption* reflects an aspect of belonging shaped by the *protomental* instinctual need to belong to a social group to survive (Miller 1998, p. 50). This frames the psycho/socio-somatic (or *protomental*) matrix from which *basic assumptions* emerge.

It is also possible to link these dynamics, with their shared and implicit patterning of emotions, to the primary emotions of Love (immature dependency needs), Hate (paranoid-schizoid hate and aggression in *fight-flight*) and Knowledge (extremes of manic curiosity seeking intrusive intimacy in the need for there to be a *pairing* in the group) (Billow 2003). It is almost as

if the individuals cluster to find a group that will express or avoid their primal emotions rather than having to experience them alone.

Bion suggests that these *basic assumptions* could either contribute to a particular work group task or undermine them. He also suggests that particular work groups are attractive to individuals because of the way they assist in splitting off and suppressing painful emotion defensively. This dynamic provides an approach that can be used to explore a person's unconscious motivation that drives him or her towards a particular chosen career.[4]

In the final section my paper makes use of this approach to explore health risks endemic to the practice of psychotherapy and practitioners' relationship with the organizational aspects of the profession.

A Couple Relationship That Somatizes Unthinkable Trauma

The first shift in the *field of study* remains within the domain of psychotherapy but moves beyond the individual to the body of the couple. In couple psychotherapy the patient is the relationship between the couple rather than two individuals - and the questions, as with all therapies, are: ‘Where does it hurt and what might it mean?’

> *A couple present a stormy cycle in their relationship of passionate sex lasting whole weekends and sickness at the threatened parting of Monday's work schedules. Their compulsive intercourse is punctuated*

by high anxiety about their fear of pregnancy. They both have a younger sibling born early in their second year of life and form a bond that has some aspects of the illusionary twin as they survive together in a sexual psychosomatic enclave over the week-end. However, the threat of return to work on Monday often leaves them depressed and physically ill. One presents with recurrent throat infections while the other gets sick in the stomach. Whoever gets sick tempts the other to remain as caretaker and their work suffers. They cannot emerge from the honeymoon stage of their relationship, yet it is a honeymoon steeped in anxiety.

The trauma of anxiety caused by the birth of a sibling, that both had experienced, occurred early in the second year of life, coinciding with what Mahler described as the *rapprochement crisis.* This material suggests a failure in psychological birth and an unremembered trauma seeking somatic expression for acute separation anxiety (Mahler *et al.* 1975).

The symptom, merger, reveals the longed for maternal body lost at the birth of the sibling. It also describes the fluid nature of the roles in the process of somatization where there is one body for two (McDougall 1989, pp. 141-61). This shapes the competition within the couple to be the infant in the primal caretaking relationship, while excluding the possibility that there could ever be a third represented by the dreaded newborn sibling.

This presentation evokes Robin Skynner's apt use of the biblical phrase for his book on family psychotherapy, *One Flesh, Separate Persons*, to describe the psychological challenges facing a couple as they develop a rhythm of

safety in moving into and out of intimacy when there has been a developmental crisis in both their lives (Skynner 1975). Neither partner could recognize and work through the destructive emotions that were attacking their capacity to develop and distinguish themselves, one from the other. Each partner, and indeed the couple relationship itself, encapsulated the unconscious conflict. This can be seen as a psychosomatic sickening system with a parasitic aspect in the way each uses the other as accomplice to their own cloying regression, by attacking development and the work of the other.

A Group's Headache Expressed in An Individual

The focus for exploration shifts now to the relationship between the individual and the group with its *protomental* matrix of unconscious experience waiting to be brought to life.

> *A member of a weekly analytic psychotherapy group misses a lot of sessions because of migraines. She is an important leader in the group, offering deep attunement to the suffering of others and an insight that befits someone who is the pastoral deputy head in a large comprehensive school. In what appears as an un-negotiated procedure, each person in the group is related to by one other member in turn. In some ways this is reminiscent of the kind of counselling training group where demonstration counselling sessions are held with a group observing to give feedback on skills. She adds to the prevailing group culture of care and concern that masks and swallows any possibility of conflict, competition and anger. These she deals with effectively in her own work where she has gained a reputation for mediation in conflicted situations. Her other role in the group is to feel in retreat and disengaged especially when members solicitously suggest it is her turn to reveal her story.*
>
> *In one session she describes her previous week's migraine that kept her from the group as a 'blinding' and 'furious headache'. She retires to her bed in a darkened room to deal with the torment of sensations and pain in her head. She seeks the feeling that her body is floating away from her mind on a womb-like sea of serenity and comfort. Her associations take her to experiences where as a child she felt at the mercy of her parents' stormy relationship breaking down, leaving her to keep the peace in the family and avoid provoking anyone, finding her only comfort in solitude.*
>
> *Other members offer gentle solace, taking the cue from her leadership style whereby she has shaped the group. It is like an agreement on an attempted cure, with each member taking a turn to empathize and reveal their own example of comfort with days off sick, bed rest, quiet music, massages, each solace covertly competing with the others for soothing and quieting the noise of the pained body. In my own countertransference I am made to feel redundant (a) as a therapist, (b) as a leader of the group that already has its own leader/ therapist, (c) as a possible dependable or comforting parent figure, or (d) as a sexual being. If I am any kind of parent, it is one who is not*

seen and it reminded me, at the time, of neglected or abandoned children who in scanning a room appear not to see their own mother.

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In a subsequent session after some of these issues have been interpreted and worked through, the group appears ready for dream work. One group member has the dream of a mother who can be seen with one eye, but the other can see only a migraine-type haloed blur. Eventually this leads to the migraine sufferer revealing her sense of envious competition with others that they might have had deeper and longer individual therapies with the group conductor, signifying a lost experience of childhood that cannot be restored. In consequence the group's migraines, expressed through the body of one of its members, reduce in frequency, and the group develops a readiness to face a new round of dealing more robustly with aggressive and sexual experience through a different member.

The Body of the Individual and the Body of the Group

The body of this group[5] has produced an ailment and an attempted cure. Both suppress and defend against other more painful and conflicted emotions related to failed dependency in primary love and failed sexual intimacy re-cycled down the generations in the experience of group members. On the other hand the group has used this dynamic as a frontier of development, albeit a limited one. In this sense it could be said that it portrays aspects of the *anti-group*, described by Nitsun (1996), whose dynamic is a necessary prelude to the group's development.

There remains the question about the relationship between the individual's bodily somatization and the body of the group that could be thought of as presenting one of its members with a recurring somatic disorder that they are determined to cure with therapeutic understanding and kindness. One theme of the group described above is that there are many family experiences of failed and conflicted marriages, both past and current. But so too has the group a failed marriage in that the group setting fails to provide a fantasy opportunity for marriage with any one of its members or indeed its leader as sexuality has been difficult for the group to explore and express, perhaps because of the rivalry that it is feared may ensue.

The group illustrates the patterning of emotions and behaviour predicated upon the need to belong to the dominant demands of the group culture,

shaped by the valency of one of its members. Members lose their individual skins that hold them together and borrow instead a group skin, represented in the prescribed maternal and physical care (Anzieu 1984[1975], 1989[1974], 1990; Ulnik 2007).

Using Bion's analysis, the body of this group can be interpreted as dominated by the desire for a paired intimacy. The child of the group, the hoped for outcome, was to be maternal consolation and empathic attention for the painful and complex life situations of individual members. In this phantasy the unborn aspects of the personalities of members might have safe passage and birth into the outside world.

The possibility for conflict and rivalry in the group, an expected aspect of any sibling peer experience, was massaged out of consciousness. To achieve

this denial the group provided an emotional climate characterized by dependency with the reassurance of its half-absent group member as leader. What these processes reveal is the way the *protomental* experience of fight-flight was transformed out of consciousness into a symptom (the migraine), producing a group held together through, and embodying, the *basic assumption* of *dependency.*

Having established the possibility of somatic symptoms being an expression of the *protomental* aspects of a group through group analysis, the argument now turns to a larger social group, an organizational work body.

Occupational Health Where the Work Organization Gets under the Skin of an Individual

The field of enquiry now undergoes a further step-shift to explore the relation between psychosomatics and the psychodynamics of organizational systems.

> *A single woman holds a pastoral and counselling role in education, her weak spot is recurring stomach upsets. These take her away from the work she loves, in which she has earned a reputation for considerable insight and a capacity to say things to people and in meetings that others dare not say. She makes up for her absences by working far more overtime than needed. There is a contrast between hugely effective and creative work that is deeply satisfying on the one hand, and, on the other, the dreadful experience of being*

incapacitated by a stomach that disables her by threatening to turn literally inside out with no notice.

She describes a childhood fraught with a bad conscience about a mother who was intensely anxious, especially around food and feeding. Her dog dies and she is thrown into an abject depression at having no body to pet and cuddle when she gets home from work. Her internal world has two contrasting elements. One is a healthy insightful and creative mind able to engage professionally in her caring role. The other is an encapsulated maddening misery characterized by punishment, guilt and failure to exploit a considerable capacity for friendships, cultural activity and self-care. During bouts of depression, the dog had been part of recovery. It was his fur she loved to pet and fondle, with a desire that might easily have belonged to a lover if it were not so clearly part of a frustrated child's desire for a mother who would enjoy contact with her skin.

The failing school where she works is in a deprived area and has recently had a new head who has retrieved it from special measures imposed by the education authority. Part of the cost of this cure has been a new culture where staff are encouraged to commit to a series of targets. Lunch and coffee breaks are abandoned and a culture develops where a punishing work regime leaves staff with few resources for their own lives. Absence from work increases among staff who, like the patient, feel bad about being absent and persist in being present even when they are unwell. These problems of absenteeism and presenteeism could be replicated in many current public services as well as other precarious organizations.

It is characteristic of organizational systems that first order change to solve organizational problems can cause secondary difficulties where the underlying system dynamics are not addressed (Campbell & Huffington 2008). The cure taken for special measures in the school creates a culture of punishing overwork with new kinds of problems and levels of sickness. But there remain a series of questions. How does the individual encapsulated psychosomatic symptom relate to the organization's ills? Is it that people with encapsulated psychosomatic illness are drawn to organizations that will punish them by becoming their persecuting object? Is the organization itself psycho-toxic? And from the perspective of the organization, how can the contrasting experiences of absenteeism and presenteeism be understood and addressed? In both the

body of the organization and the body of the individual there appears to be a mutually reinforcing internalized and externalized object relation of a persecuting kind (Obholzer & Roberts 1994).

This illustration (see Figure 1) shows how an organization's strategic difficulties, in matching tasks and resources, can be revealed in the diagnosis of an individual's symptoms. This might show some of the epidemic *protomental* dynamics that need to be analysed and addressed.[7]

The paper now turns to the field of epidemiology to explore the possible relationship between the social aspect of *protomental* dynamics and stress illness.

Stress Illness and its Epidemic Social Dynamics[8]

Can societal dynamics be enlightened by group dynamics? In describing the nature of the *protomental* Bion writes: '... the sphere of proto-mental events cannot be understood by reference to the individual alone' (Bion 1962, p. 103). I have tried to illustrate this above in each of the step changes in

the *field of study.* The argument now turns to the final step in putting the workplace and the wider society 'on the couch'. The suggestion is that group defences employed by staff are linked to particular stress-related illnesses and the working conditions in which they occur.

Example of the Dynamics of Psycho/Socio-Somatic Disease in Staff Illness

In proposing the study of *group disease*, Bion writes:

> *I should like to have evidence about such diseases as tuberculosis, diabetes and others, particularly with regard to such aspects of fluctuations in numbers of cases, virulence, and distribution as were not readily explicable in terms of anatomy, physiology and other disciplines that are normally the stock-in-trade of Public Health investigations. (Bion 1962, p. 105)*

He proposes that useful data might be found from research reporting the statistical occurrence of disease.

> *In a hospital occupational health department, type two diabetes was the most frequently diagnosed symptom in staff in the accident service (emergency room). The staff doctor had diagnosed the cause as related to the practice of staff squeezing breaks into a crisis ridden work schedule, and resorting to unhealthy, readily available fast food. He prescribed the cure of providing healthy snacks and regular time out.*[9]

It is possible to consider analysing this data in terms of the emotional stress that staff receive from patients. Work pressure often involves working with patients abusing alcohol and drugs, and being caught up in physical violence and vehicle accidents. Abused, damaged and neglected bodies punctuate the work. The aggressive somatic demand for cure and care suggests a possible *basic assumption* dynamic of *flight* from self-care and *fight* for resources from the health service. In the face of such an infectious emotional onslaught, it could be suggested that staff found it difficult to provide for their own healthy nourishment. To put it another way, in the countertransference, the staff showed signs of having caught their patients' infectious and epidemic psycho/socio-somatic disease. Keeping safe and well is at risk in this work situation.

Protomental Epidemiology of Social Disease

Torres researches the *protomental* dynamics of three particular diseases: psychosomatics, addictions and para-suicide. These modern, stress-related disease groups each have their own epidemiological evidence with characteristics that are biological, psychological and social. He explores the *basic assumption* emotional *valency* of people within each cohort (Torres 2006, 2010a, 2010b).

Torres' research tests the hypotheses that, in each disease group, there is a *protomental* link to a group dynamic that will suppress painful emotion.

Thus he finds evidence that connects addictions with the need to suppress experience of failed *dependency* with its needs for primary love (-*L*) and secure attachment. Psycho-somatic symptoms and associated alexythymia, are affiliated to a need to suppress aggression and *fight-flight* responses, with the consequent attack on the immune system and the emotion of hatred (-*H*) turned against the self and/or others. Suicidal behaviours are affiliated with the need to suppress intimate and sexual emotions with their associated *pairing* group dynamics and need to avoid natural curiosity of relating (-*K*). Bion's negative sign attached to each of these basic emotions indicates the *thanatic* principle to undo or destroy, in these cases through somatizations (Billow 2003).

Bion suggests a further source of understanding of the dynamics of a *group disease.* He explores the possibility that the physical manifestation of a disease (*protomental system*) might have a psychological counterpart (*basic assumption*). He suggests that it is not so much the symbolic representation of the disease that tells us about the underlying *basic assumption* dynamic, but rather the dynamic involved in the attempt at cure evoked in responses to the disease.

His example is that the cure for tuberculosis, until the arrival of antibiotics in the mid-20th century, was primal care with bed rest, while the social attitude to TB drew the accusation of malingering before the TB lesion was medically established. This led him to affiliate (not a causal connection) tuberculosis with *protomental system dependency.* Bion's idea was that the clue for the affiliated or reciprocal *protomental* system could be provided by the chosen treatment regime for the disease with its reciprocal dynamic. In the example of the Accident and Emergency department above, the attempted cure was in the reliable provision of healthy food. However, it is clear that more complex interventions are needed to address the emotional source of stresses for the staff in that particular work place.

These ideas will now be used to explore the health risks endemic to the psychotherapy profession. Such risks have bodily, emotional and professional group elements.

Occupational Health and Safety Risks Endemic in the Psychotherapy Professions[10]

Within analytic work the task is to survive the experience of being on the receiving end of what Bion described as the invasion of *beta elements* across the *contact barrier* between patient and therapist with all their unconscious libidinal, aggressive, seductive and bombarding projections. It also means hearing horrid and tragic stories of inhumanity, tales that are full of seductive and misplaced sexuality as well as the courage that people find to live honestly with themselves and others. The essence of the analytic task is to survive this emotional bombardment and to provide thoughtful contact,

rather than retaliating or being seduced, and to provide emotional containment through interpretation and reliability.

Psychotherapists in private practice work in considerable isolation, left alone to resolve issues of reputation, professional identity, personal and professional development and emotional support. These can be met with a portfolio of self-designed Continuing Professional Development (CPD) activities and through affiliation to psychotherapy organizational bodies.

It is a recognized requirement for trainee therapists to undergo personal analysis in order to explore their experiences of failed dependency and intimacy so that they do not impinge on patients (Morgan-Jones with Abram 2001). Despite this fact, professional organizations are often treated by each individual therapist as an arena for the unconscious wish to be able to depend on an organization which precisely reflects his or her own values and school of thought. Eisold (1994), for instance, has written about the intolerance of diversity in training Institutes. He suggests that idealized attachments to paired relationships with training analyst or supervisors with their particular school of thought can create a foreclosed attitude to new thinking, and a demeaning of other perspectives.

It would be possible to take a number of routes into exploring the health and safety risks of the psychoanalytic psychotherapist's role. Here the attempt is made to group them around *basic assumption/protomental valencies* that reveal the unconscious leanings of the analyst towards their professional work group. This is an example of what David Armstrong (2005) from the Tavistock Institute describes as '*The organization in the mind*' as a way of pointing to an internalized organizational object relation. This points to the possibility of analysing the

ways in which social group dynamics within the profession are used to suppress painful experience.

There follows an initial exploration of such health risks.

Dependency Risks

The fundamental risk being explored here is that the practitioner fails to adequately look after him- or herself, thereby creating the risk of embodying a failing, distorting or impairing physical and emotional container. At an emotional level primary love becomes distorted as addictive greed and/or neglect. The following examples apply Torres' idea of a link between addictive personality traits and the dynamics of dependency and its failures. The addictive tendency is revealed in the workaholic habits of many therapists that have both a collective professional and an individual point of reference (Torres 2006).

There is the ergonomic risk about design of chair to support the body and mind, the shape of the working day and the psycho-physical well-being so that patients rely on more than the therapist's strong genetic constitution.

The risk that the desire to heal others and repair vicariously their own internal narcissistic wounds, what Freud called *furor curandi* [fury to be healing], will drive therapists to ignore their own physical, emotional and sexual needs in a way that will risk illness thereby endangering their professional practice and livelihood as well as the survival and good reputation of their professional body. Vicarious living through the patient can become a toxic drug to manage uncontained internal excitations.

Psychotherapists may be at risk from the ambition of their referrers. Main (1989) wrote in *The Ailment* about his research into why particular strains and stresses had caused illness and sick leave in staff at the Cassel Hospital. These therapists had shown that they were well able to deal with the emotional demands of very needy and manipulative patients. What he found suggested that particular absences from work coincided with the experience of ignoring a feeling of reluctance to take on a patient in the face of a referral from a colleague who tended to describe the patient as particularly deserving or rewarding. The task at assessment is to listen carefully not just to whether the patient has the resources to do the analytic work but whether the therapist has. The question is: ‘Are you, the therapist not only good for the work, but also is

the work good for you?' It is one that is usually asked - but not always, sometimes with tragic results - at interviews before the start of training. Perhaps it needs to be asked by the therapist of themselves with each newly assessed patient as well as at different ages and career stages.

Pairing Risks

The fundamental risk explored here is the possibility of the pull for emotional knowledge and intimacy that threatens the analytic frame and boundaries. This can be found in the excessively caressing interpretation and the vicissitudes of a seductive empathy that suppress aggressive drives. In these examples, valency towards a pairing group dynamic is linked with professional suicide, the result of a *folie à deux* with the destructive idealization and sexualization of the therapeutic role (Torres 2006).

Among other emotional experiences therapists have to deal with is a particular oscillation of emotional experience between being rejected and of no importance to the patient as well as being a hugely important life-line. This means being on the receiving end of a primitive dependency and all the emotions that attend the infant dependent on the presence, indeed the embodied capacity, of the therapist. A training analysis is a *sine qua non* requirement in order to survive these emotional states and relatedness without enacting feelings of grandiosity or suffering utter despondency at the depth of the primitive transference. In this context the *pairing* risk is of sexual acting out in the tradition of the gods seeking their entitlement as their omniscience entitles them.

Current emphasis on countertransference responsiveness opens the analyst to both loving and hating feelings and the risk of acting out sadistically or sexually in a misguided venture of reparation disguising veiled hostility and exploitation. These are the boundary violations which narcissistic therapists sometimes fail to own (Gabbard & Lester 2003; Hopkins 2008).

Flight-Fight Risks

The fundamental risk here is dealing with the emotional challenge of hatred in the work. The avoidance in flight and the temptations of fight demand to be metabolized into providing energy and restraint in the pacing of interpretation of a patient's material. The bodily risks derive from adrenalin fuelled fight-flight dynamics that form the matrix for alexithymia and psychosomatic ailments

(Torres 2006). Failure to articulate the body and its sexuality, whether of the individual body, the professional body or the body of theory, puts each of these domains at risk.

A *flight*-based risk might be excessive interest in the mental and theoretical aspects of the work, much as these can act as an impetus to avoid burn-out and compassion fatigue. However, this can be at the expense of awareness of the therapist's own body. One example might be the excessive use of psychosomatic interpretations that ignore the limits of the psychoanalytic and so ignore inevitable experiences of medical illness and the failure of the therapist to engage with their own bodily health and well-being.

Another risk might be a foreclosed approach which sees the psychoanalytic world and its professional politics and debates as a self-sufficient whole. Such an approach offers little time, energy and availability to consider the work in the context of a wider social and political environment that we might call the body politic.

Idealizing an approach or theoretical position risks demeaning colleagues. It can also risk fighting the analytic establishment for its exclusive promotion. It can detract energy from the struggle to understand particular patients or indeed how to promote psychoanalytic work to wider groups in society. The splits in the profession testify to this internal warfare.

No doubt there are more professional health and safety risks and debate is to be welcomed. Perhaps the key health and safety risk goes beyond the fact that individual bodies of psychotherapists can be neglected. The institutional bodies that represent us may be so destructively self-absorbed with schism and strife that they fail to provide healthy containment and transformation.

Mentoring in Psychoanalytic Psychotherapy

Formal and informal mentoring which is available through vital, though often unacknowledged resources, is an often disregarded resource within analytic institutes. These include the *femme sage* (male or female)[11] to whom

colleagues turn when they are sick or suffering from work-related challenges and opportunities. Mentoring occurs informally in one-off consultations, meetings of peers, meetings over a conference coffee, or supervision sessions that extend beyond clinical issues to review the supervisee's relation to the

work, work-life balance or personal and professional development. The outcome may be further analysis, specific supervision or some specific or non-specific pointer to an aspect of compromise formation or life enrichment that may have been overlooked. Essentially, mentoring provides the emotional containment of a consultation and may include old-fashioned health advice, whether physical, psychic or social, or else a group or organizational interpretation. In a good working organization these topics are often covered in an annual staff appraisal interview, although I hesitate to prescribe this in any formal way as, in the current climate, it might invite a required format and a policy.

In my own supervision practice I try to make space for such mentoring opportunities, whether to address them in supervision or to suggest that they may be better addressed elsewhere. They naturally include: work-life balance, attention to the effects of illness, health and ageing, career plans including retirement, migrating work context or region, adequate professional wills, contribution to the wider organization, to name but a few.

I have noticed across the decades that aspects of such mentoring work have not only been a feature of my own use of supervision and of informal consultations with colleagues, but that supervisees have often made use of supervision in this way. Neither I nor they have conceptualized it as staff appraisal, mentoring, career advice or occupational health consultation. However, having worked in consulting to organizations around such issues, I have recently come to see that these concerns belong to this under-articulated field.[12] It could be seen as part of belonging to what might be termed the therapeutic community[13] with its distinctive culture.

Having stated the need for ongoing containment throughout analytic careers, it is less easy to see where such might be promoted. Supervision, with its rightful clinical focus on the analytic relationship, can all too easily avoid such tasks. Therapeutic consultation or sessions with an analyst to address a specific life issue or quandary do not necessarily address the relation between a person and their work, or their relationship to the professional bodies to which they belong.

Perhaps in conclusion I could suggest that this aspect of the public health needs of the profession has been embryonic, a premonition of a *protomental* need seeking to be born.

Conclusion

In this paper I have attempted to trace the messages from the body and its relation to larger ‘bodies’; messages which can be spoken and heard using

the technical approach of psychoanalytic enquiry that moves from premonition to thoughtful contact. I have suggested that the individual experience of the body, and especially the cultural language to express individual bodily experience, is part of embodiment in a wider social group. I have drawn links between these experiences and health and safety issues thrown up in a number of working environments, including the consulting room. Finally, I have proposed the importance of mentoring for those who practise analytically, for the safety of themselves, their patients and the corporate institutional bodies whom they represent.

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Notes

Versions of this paper have been presented to the Brighton Association of Psychodynamic Counselling, Psychotherapy Sussex and the London Centre for Psychotherapy.

Re-reading this chapter provoked the experience, as so often seems to happen with Bion's writings, that, despite having had the book on my shelves for 45 years, and read it several times, I felt as if I were reading it for the first time.

Clinically and in consultancy practice I have been consulted by a number of people and groups who were experiencing stress-based illness in relation to work (Morgan-Jones 2005). I was also involved over a 7 year period with eight discrete situations, half of them in relation to psychotherapists, where there had been boundary violations (Morgan-Jones 2006a). I was seeking frameworks that might explore the nature of physical, emotional and

organizational health and safety risks within the work place including in the psychotherapy profession. This alerted me to the possibility of exploring group diseases with their own distinctive epidemiology.

I have illustrated this hypothesis in a paper entitled: 'The desire for the work group and its protomental embodiment' (Morgan-Jones 2007b, 2010).

This phrase linguistically makes use of the metaphor of the body to describe the complexity of belonging to a group that has cognitive, symbolic and physical meanings that cluster into a whole object relation available to be internalized.

Cartoon conceived by author, drawn by Dylan Barwick of http://www.tiptoptoons/

For application of epidemic protomental/basic assumption dynamics to the failure of financial bodies, see Tuckett and Taffler (2008) and Dixon and Morgan-Jones (2010).

This paper does not explore the rich resource in the fast growing development of thinking in the social sciences exploring the sociology and anthropology of the body, medicine and the sick role (James & Hockey 2007; Malacrida & Low 2008; Wolkowitz 2006).

This is one of a number of examples illustrated in another paper that proposes the term 'retainment' as a way of describing: 'the emotional management of the presence and commitment of members of a team for a work task' (Morgan-Jones 2007a, 2010).

Or how the work can get under the skin of the individual or professional body (Morgan-Jones & Torres 2009).

'femme sage' is the name given by community workers or social scientists in describing a woman of wisdom in a local neighbourhood who knows from experience how to ... often in relation to childbirth or infant care and who can accompany someone through that experience.

In response to consulting to organizations in several fields presenting work force health issues, I developed a service entitled: Work Force Health; Consulting and Research (Morgan-Jones 2005, 2006a, 2006b, 2007a, 2007b, 2010).

I am thinking here of the concept of 'Community as Doctor', used to describe the workings of the therapeutic community at the Henderson Hospital (Rapoport 1960).

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