Empathy , transference and counter-transference in group analysis and analytic group psychotherapy – its interaction
Paper Panel

***Panel** Empathy , transference and counter-transference in group analysis and analytic group psychotherapy – its interaction*

Guilherme Ferreira
Psychiatrist;
Tutor Member of Portuguese Group
Analytic Society;
Full Member da Group Analytic
Society London
ag.ferreira@netcabo.pt

Groupanalysis and Group Analytic Psychotherapy: Similarities and differences

The Portuguese Group Analytic Society and the Brazilian Association of Group Analytic Psychotherapy have maintained, over the last few years, strong ties which began in 1922, under my presidency and which have continued, since then, through a process of organisation and structuring which has resulted in the holding of biannual meetings, alternately in Portugal and Brazil.

One of our concerns, has always been, to compare the theoretical and technical bases (and its theory) and results of our two approaches.

They are founded, in principle, upon essentially different concepts: group analysis sprang from the work of S. H. Foulkes and his conceptions wee modified, in Portugal by E. L Cortesão, who stressed the importance of the psychoanalytic component, from where it originates. He also considered that the group analyst was the essential figure of the therapeutic process whose action was expressed through what he called designated as group analytic pattern. This pattern would transmit and develop the therapeutic action of the group through what Foulkes designated as group analytic matrix, a concept he found in the homologous point of view of Ruesh and Bateson, defined in his work "Communication: the social matrix of Psychiatry". The object of the therapeutic action of the group that we may designate as group analytic process and which is set in motion by the group analyst and planned and developed in conjunction with the group. It consists of the working through of the group transferencial neurosis (defined in relation to each member of the group and to the respective matrix of the latter) – or any other equivalent entity, in the sense that Etchegoyen gave to the necessity of forming a stabilized transferencial situation, in the same way as the transferencial psychosis, the perversion of transference, the organization of a border-line or narcissistic transferencial structure, or finally, the organisation of a self-object transference, according to and in accordance with the personality structure of each individual – and the individualization of the selves.

If the second of these objectives is common to all group therapies, whether they be analytic or not, and is intimately connected to the processes of socialization, the first is specific to group analysis and, even here, only recognised by the Portuguese school, since Foulkes and the English school defend that at the base of therapeutic action lies the training of the Ego in action. Also in other group analytic techniques it is rare to find anyone who defends its existence, as is the case of Glatzer (E.U.A.) or of Mário Marrone (Italy), the latter moreover also in the context of group analysis. It is, furthermore, this conception which gives the points of view of the Portuguese school a truly psychoanalytic perspective.

It is in the context of the interaction matrix-pattern and through the organisation and working through of the stabilized transferencial situations already mentioned that the evolution of the internal relational matrixes takes place, in accordance with the respective concept of Maria Rita Leal of the different elements which compose the group. Therefore, the group functions as a network of relationship, communication and verbalization (and of working through in the words of Cortesão), in which those interactions referred to above take on various forms from those expressed globally and completely, those which only claim to do so, from those conscious and manifest, from those unconscious and latent, from those verbal and non-verbal and the answers which are also understood by the same type of communications. It is in this context that the internal relational matrixes interact, as we have just mentioned and which Foulkes, on the other hand, preferred to call personal matrixes of the group and which is organised and is afterwards, worked through, using Freud's own expression, a structured transferencial situation. This working through comes about through alterations which occur in the respective object relations and seem to occur in the following manner: the internal object relations will determine the external object relations and the alterations having occurred in the latter, in turn, will bring about in the first, thus determining the therapeutic process itself.

We are now, at least in the conception of the Portuguese school, facing a specific conceptualization which allows us to explain, in a particular way the Group analytic therapeutic process. But, basically, this situation occurs within the context of identical facts or, at least similar, which have occurred in other group psychotherapies with an analytic base.

Some of these approaches have evolved, in fact, in the context of modifications connected to the evolution of psychoanalytic theory itself, and as such, include in their conceptualizations the perspectives of the theory of object relations (ORT), psychology of the Ego and psychology of the self, that is to say, all perspectives, that groupanalysis has also incorporated in the last few years, as we saw above when we spoke about the importance of ORT in the groupanalytic process. Taking all these perspectives together, Cortesão even affirms that Freudian metapsychology is

related, through the adaptive and psychosocial points of view of Rapaport, within the psychology of the Ego, to the perspectives introduced by ORT.
But these perspectives can be equally found in other types of analytic based group psychotherapy which also adopt them although not in such an integrated way, as groupanalysis did, but, unidirectional.
The Brazilian Association with branches in the major states of Brazil, although situated primarily in the respective capital cities (Rio de Janeiro, S. Paulo, Recife, Porto Alegre) presents a collection of influences which are considerably
more heterogeneous, and which vary, in fact, according to the different basic nucleus (Bion, Slavson, Wolf & Schwarz, Foulkes, Yalom).
Most Brazilian authors, on the whole, look to Bion, whose influence is due to his writings on groups, but also show the influence of other Kleinian authors who worked in Brazil, which constitute a strong current, namely David Zimmerman, with whom they had a very close relationship, and whose work they studied in particular whilst not forgetting the importance, in this action of the Argentinean group, in which the figure of Pichon Rivière held sway.
But we must not forget the fundamental factor, the presence of Bion in Brazil, where he held important conferences and published the first edition of some of his work (Bion's Brazilian Lectures, A Memoir of the future – Book one: the dream, Book two: The past presented).
And so, Bion's influence is not then limited to his initial paper "Group experiences, written in 1948-51, although only published in 1961 by Tavistock, and in which he put forward the conceptions of basic presuppositions (dependence,
struggle and escape, coupling), which explains the functioning of the group as a whole, a fact which still today is defended by many group psychotherapists, and sometimes even with a perspective of a non-analytic approach. But, all his later theorization is included in it. Impressively, Bion developed throughout his life, a set of complex conceptions of great importance for psychoanalysis. Taking as his starting point, precisely, the work with groups already mentioned and later, from the effect with psychotics which he achieved in the wake left by other Kleinian authors, he formulated, in the first place, his theory of attachment and his concept of grade and, later, developed philosophical conceptions in which he set out a theory of knowledge and a theory of transformation, which led to his points of view to acquire mathematical or mystical perspectives, simultaneously or alternately.
These conceptions, naturally, also led him to modify his psychoanalytic technique which had repercussions in the group psychotherapies which were influenced by his points of view forming the centre of a process "without improvements, without desires and without understanding", but in which the psychoanalyst took the role of container in relation to the patient, over the attachment on which he acted.
All these complex conceptions were assimilated by the Brazilian Association of Group Analytic Psychotherapy and constitute the basis of its theorization.
But, as we have already referred to above, this was not the only influence, since the conceptions of the different nuclei of the Association were also determined by other authors already mentioned and also as a result of the evolution of psychoanalysis itself, also referred to above and which found its repercussions in group analysis, as it is practised in Lisbon. The influence of Foulkes in Miller de Paiva, is of course well-known and their correspondence reveals in their exchange of opinions a considerable number of parallel points of view.
We can, therefore, from what we have said above, put forward three conclusions which point towards possible areas of further investigation:
1. Group analysis, being essentially determined by the works of Foulkes, although with its general lines of thought modified by those of Cortesão, Leal and other authors and group psychotherapy with an analytic basis as conceived by the ABPAG, along general lines, by the Works of Bion, although here, one cannot speak of a basis as organized or structured as for the first school mentioned, are there not, naturally, important differences in the techniques and therapeutic actions of the two group therapies mentioned?
2. The work produced by the different authors connected to the ABPAG do not specifically put forward the hypothesis of the formation of a group transference (or equivalent situation) and, even les so, of its working through? What will the repercussions be in its technique and in the theory of technique?
3. The exchange of points of view and the biannual meetings held by our two societies, will have contributed to an approximation of their interventions and the respective technique and theory of technique, as one would hope.
It was, therefore, essentially to clarify these hypotheses and to confirm subsequently what techniques and theory of technique were being used, and on what they were founded, that this present study was carried out and which we hope to clarify in the papers put forward.
The excellent papers presented by Doctors Ana Sofia Nava and Julio Mello Filho appear to approximate to the second and third hypothesis and, on the contrary distance themselves from the first.
Consequently, although Dr. Ana Sofia Nava has pointed out the importance of the concepts of Foulkes, Cortesão and Leal in the establishing of the theory and the theory of technique in group analysis, the comparison of these two texts, shows, on the contrary, a considerable approximation between the two approaches.
In effect, the whole text of Dr. Julio de Mello Filho frequently centres its interventions on the transferencial interpretation, and even on the use of the counter-transference, which he explains in a very direct way and which he uses as a therapeutic tool, following the ideas of P. Heiman. The latter's direct expression of the negative elements, which appear clear and frank in the examples given, will lead to the elaboration of the negative which is fundamental towards enabling the working through of the neurosis of group transference.
Doctor Carla Penna, in her commentary on the paper presented by Dr. Ana Sofia Nava, affirms that Dr. Julio de Mello Filho had a Winnicottian based training. We should underline that the concepts of Winnicott also influence groupanalysis, through the viewpoints of ORT, drawn up above all by the English orientated group, to which she

belongs. It follows then naturally, that there should be certain proximity in the two approaches in the examples presented in this panel.
Also, in1985, Malcolm Pines published a collection of papers showing the importance of Bion in the evolution of group psychotherapy and in which he tried to find a connection and inter-influence, not always successfully, between the concepts of Bion and of Foulkes, in an attempt to show that they were not so far apart as it might appear.
Finally, the papers presented at this forum and their respective commentaries, presented by Doctors. Carla Penna and Claudio de Moraes Sarmento, which are also included here show a great similarity between the two therapeutic processes referred to and there theoretical fundamentals, and which, moreover, come within our working hypotheses.

References

Bion, W. R. (1948-51) – *"Experiences in group"* Tavistock, London (1961)
Bion, W. R. (1977) – *"A memoir of the future, Book two: the past presented",* Reprinted by Karnac, London 1990
Bion, W. R. (1977) – "*Seven servants: four works", by Wilfred Bion",* Jason Aronvon, N.Y.
Bion, W. R. (1977) – *"Two papers: The Grid and Ceasure*", Reprinted by Karnac, London (1989)
Bion, W. R. (1992) – *"Cogitations*", Karnac, London.
Bléandonu, G (1990) – *"Wilfred Bion: his life and work (1897-1979)"*, The Guilford Press, N. Y.
Cortesão, E. L. (1982) – *"Grupanálise: teoria e técnica"* F.C.G., Lisboa, S.d.
Etchegoyen, H. (1991) –*"The fundamental of psychoanalytic technique",* Karnac Books, London
Foulkes, S.H. (1967) – *"Therapeutic group-analysis"*, Allen & Unwin, London, 1964
Foulkes, S. H. (1975) – *"Group-Analytic Psychotherapy: Methods and principles"* – Gordon & Breach, London
Foulkes, S. H. and Anthony, E. J.(1965) – *"Group psychotherapy. The psychoanalytic approach"* Penguin Books, London, 1ª ed, 1957; 2ª ed, 1965
Leal, M. R. (1994) –*"Grupanálise: Um percurso, 1963-1993",* Sociedade Portuguesa de Grupanálise, Lisboa.
Pines, M. (ed by) (1985) – *"Bion and Group Psychotherapy",* Rutledge & Kegan Paul, London
Zimmerman, D. (1995) – *"Bion – Da teoria à prática*", Artes Médicas, Porto Alegre

Ana Sofia Nava
Psychiatrist;
Full Member of the Portuguese
Group Analytic Society;
Full Member of the Group Analytic
Society London
clinicatagide@netcabo.pt

Pattern / Matrix / Group Analytic Process / Empathy

The theory of groupanalytic technique rests on various fundamental concepts, namely, pattern matrix and groupanalytic process.
In this paper I will try to clarify how these concepts are defined theoretically and the way in which they intertwine in clinical practice and consubstantiate groupanalytic technique, as it is generally practised by Portuguese groupanalysts.
Finally I will look at the way one of the most important tools in psychotherapies: empathy is integrated in the mode of groupanalytic work, previously above.

PATTERN

Cortesão (1988) investigated the semantic origin of the word pattern in latin, Spanish, French and English. In his words:
Pattern is derived from the medieval French term "patron" and this, in turn, originates from the latin "pater" and "patronus". In this sense pattern can mean imitation, copy, to look like, to sketch, draw, plan a pattern (for), or prefigure. However, latin presents the hypothesis that the semantologic trunk comes from the word pã (seed) with the connotation of to sow, feed and foment.
It is from this last connotation that I coined the concept of groupanalytic pattern, in the sense of something that the groupanalyst transmits in the groupanalytic matrix. The connotations derived from the first meaning – of "pater" and "patronus" – are not pertinent for my definition. In truth the groupanalyst should not offer himself as a protector or a model; neither should he direct either actively or didactively.
Consequently Cortesão (1989) proposed the following definition of pattern: nature od specific attitudes that the groupanalyst transmits and sustains in the groupanalytic matrix as an interpreting function that encourages and develops the Groupanalytic process.
In a wider definition we could say that the pattern is the set of characteristics and competences that a psychotherapist uses to bring about a psychotherapy.
At the time this concept was defind by Cortesão it created some polemic and discussion with Foulkes. In short, Foulkes (1967) considered that the pattern was a kind of imprint coined by the groupanalyst in the group matrix, while Cortesão retorted that the groupanalyst was a transmitter, a catalizer, a fertilizer and never a leader who imposed his model.
The pattern can be considered, from the theoretical point of view, along three vertices: its nature, its function and its purpose. These include, schematically the following aspects which I will consider later:

I. Nature

1. personal qualities
2. analytic function
3. theoretical formation

II. Function

1. rules
2. specific attitudes

III. Purpose

1. insight
2. change / cure

I. Nature

As to the nature of the pattern, it depends obviously on the nature of the groupanalyst himself as a person.
We might also add, safeguarding the artificiality of theoretical divisions that the person of the groupanalyst is made up of the following aspects:
1) His **personality**, which conditions all his behaviour as groupanalyst. This behaviour assumes verbal and non verbal forms. And as regards the latter, I am referring not only to the body-language of the groupanalyst, but also to the way he organizes the physical space where the group sessions take place, which, as it is obvious, is a result of the projection of diverse aspects, both conscious and unconscious, of his personality.
2) His **character.**
3) His **internal relational matrix** (Leal, 1969), that is, the way he interiorized the interpersonal relationships of his early primordial group / his family. This will come to light when he finds himself in a group again, although now with the specific function of therapist.
4) The **Personal Analytic training** of the groupanalyst is evidently an extremely important factor for the (person of the) groupanalyst. Not only because his personal analysis conditioned changes in his personality, but also by the way he internalized/identified himself with the pattern of his own groupanalyst.
The nature of the pattern also depend on the qualities of the groupanalyst. I would like to quote some of the qualities mentioned by various authors who, have spoken about this matter: 1. refined empathy, 2. non-possessive welcome 3.genuineness (Terence Lear, 1985); 4. honesty, 5. truth (Martin Grojahn, 1985, 1987); 6. identity strutured in personal and professional terms (Earl Hopper, 1982); 7. sincerity, 8. frankness, 9. tolerance, 10. security, 11. equilibrium,12. competence (Foulkes, 1964); 13. capacity to establish a relationship (Fairbairn in Guntrip, 1977); and finally I would add 14. capacity for being in a group.
Another aspect which defines the nature of the pattern is the training of the groupanalyst. The learning of the theory and technique of groupanalysis is fundamental in order for the groupanalyst to encourage and develop the groupanalytic process, either at the level of the rules of abstinence, or as regards his interpretative function.
Training must include a practical component: the personal analysis of the groupanalyst, and a more theoretical component: the training courses administered by group analytic societies, continuous training (scientific sessions, national and international), and, obviously, the necessary supervision during the first years of groupanalytic activity.

II. Function

The pattern has as its function the establishment of rules and attitudes in groupanalysis.

1. Rules

As regards the rules, the groupanalyst should make an accurate selection of the elements of the group. This is fundamental for the establishment of the groupanalytic process.
The contract should be made before the patient enters the group. It should be explained that:
1) Absolute and bilateral secrecy must be adhered to, neither the groupanalyst can speak about what happens in the sessions, nor the analisand may speak about what happens in the group;
2) Contacts outside between elements of the group are forbidden;
3) The groupanalyst must not speak with family members of the patient;
4) In the group verbal communication is the norm and physical contact is not allowed (for example: the verbal expression of aggressiveness and affect is permitted, but not the physical acting out);
5) The patient must renounce the obtention of secondary gains within the group????.
The groupanalyst has the obligation to provide the physical space, assure the frequency and duration (1h30m) of the sessions He is responsible for the regularity and punctuality of the sessions. He should ensure the groupanalytic setting: the patients must be facing each other, sitting in a circle, the groupanalyst should stimulate *free floating discussion* (Foulkes, 1964) without any social censorship.

2. Attitudes

The analyst should have a series of attitudes in the sense of fomenting the groupanalytic process.
a) Analytic interventions and interpretations.
The interventions may be: questions, clarifications, confrontations, analogies or metaphors.
b) The analyst must refrain from trivial interventions/opinions which are no more than projections of his needs and unconscious desires.
c) It is also fundamental that the analyst assures the analytic reserve, that is to say he should not speak about himself. He should present a white canvas onto which the analisands may project everything that they need.
d) Various authors have defended that the attitude of the analyst should be one of passivity and not of activity. However, with the passage of time, new ideas arise which call into question the usefulness of the complete passivity of the analyst.
e) The attitude of the groupanalyst should be one of continual understanding of the binome transference/ countertransference. As we know, Freud already drew attention to the importance of this phenomenon in the evolution of an analysis and later, pointed to its therapeutic potential. Consequently the groupanalyst should be always ready to identify and understand it.
f) And finally, the groupanalyst should have an attitude of detailed examination maintained throughout the groupanalyst/groupanalisand relationship. An increasing number of contemporary analytic authors speak about the relationship established between analyst and analisand as being a therapeutic factor (for example, Stern, 1998).

It seems to me to be fundamental that, in his attitude, the groupanalyst promotes not only the space within which this phenomenon occurs, but also is always alert to what is happening at this level: that of the interpersonal relationship and not just an aseptic examination of the transference / counter-transference.

III. Purpose

Finally the aim / the objective of the pattern, it corresponds basically to the unfolding of the groupanalytic process itself.

This can be differenciated into the following aspects:

1. Promote rational and emotional insight
2. Operate significant modifications of the self
3. Proportion to the individual a structuring, differenciation and functioning of the self endowed with relative autonomy and coherent and natural dependency.

Recently some authors have looked again at this concept and made some enriching reflections.

M. Etelvina Brito (1989) compares the pattern to the exercise of the parental functionl.

Leonardo Ancona (1989) speaks about exogenous pattern – transmitted by the groupanalyst and endogenous pattern – elaboration of the endogenous pattern by the group. I think that this process is gradual and harmonious, and in such a way that at a certain point these two sides mutually interpenetrate and strength each other.

Isaura Neto (1999) speaks about how the integration of the pattern results from identification with the groupanalytic function of the groupanalyst.

I agree with the authors mentioned and would add that the pattern is, in fact, echoed in the group and amplified. This process of identification / internalization gives rise very often to the dimensions of co-therapists in the elements of a group of analysis. Although without the responsibility of being therapists, some elements of the group get some pleasure in exercising the function of co-therapist (either at the level of rules, or of attitudes). The possibility of identifying themselves exercising parental functions can thus be taught in the group until the analisands find their own originality. Without falling into exaggeration, I think that this is one of the many gains of groupanalysis that we should not disregard.

Cruz Filipe defends that the pattern should contemplate a groupanalytic attitude in the following moulds: wait patiently for the projects of the group and of the analyst have something in common, in latency, in space in time, but never with analytic therapeutic intrusion. The groupanalyst should give the time necessary. The experiencing of time in each session (of groupanalysis) is fundamental for the groupanalyst to be able to ensure and sustain the listening time, while giving due attention to the importance of the freedom of the group. The pattern assures the possibility of the creation of a maleable zone or zone of transfiguration ensuring times for deconstruction / reconstruction, which are only possible in a proposed space and not one of imposition.

MATRIX

Another very important concept for groupanalytic theory and technique is the matrix.

This concept was also defined by Cortesão in the following way:

A specific network of intercommunication, inter-relationship and interreaction, to which, through the integration of the
Groupanalytic pattern, foments the evolution of the Groupanalytic process. (Cortesão, 1989)

Foulkes prefered the following definition: *It is the hypothetical web of communication and relationship in a particular*
group. It is the terrain shared in common that in the final analysis determines the significance and the understanding of all the
verbal and non verbal communications, and interpretations (Foulkes, 1964)

Maria Rita Mendes Leal defined moreover another very important concept to understand the phenomena which occur in a session of groupanalysis – the **internal relational matrix,** which she defined as follows:

The regression induced in each of the members of the group may lead to the reactualization, not only of the parental figures,
but of the whole family group of each one. (Leal, 1969)

It corresponds to the way the individual interiorized the interpersonal relationships of his early primordial group, of the family. This model will emerge when the individual finds himself in a group once more.

GROUPANALYTIC PROCESS

In the first place, I would like to emphasize that the pattern, as promoter of the groupanalytic process, contains, implicitly, the tools for the Groupanalytic cure. Furthermore, the aims of the pattern embody the aspects that at the present time are generally agreed upon with respect to the analytic cure.

Therefore, with respect to its function, it was proposed as fundamental attitude of groupanalysis the interpretative activity and the relationship with the patient in such a way as to permit the development of the groupanalytic process and, consequently, the cure of the patients.

Or in other words, the pattern enables a space, in the heart of the group matrix, a search for explicit and implicit memories (Nava, 2003 a). These may be interpreted either at a genetic-evolutive level, or transferencial.

But there is still missing the reconstruction for a more autonomous self. Here also the pattern makes possible the space for a new affective/emotional relationship, of true encounter, which might originate the formation of new implicit memories which will form the framework for a new style of interpersonal affective way of relating, within a restructured personality

For Pines (1998), the role of leader of the group is to stimulate and represent the apprenticeship through experience and to oppose powerful cohesive structures of resistance. In this sense the pattern permits its members to map out a path of coherent development, that is if we think of the group in terms of growing coherence, and as such, we can equate an integrity that makes the whole and the relationships between the parts more clear and manifest.

Guilherme Ferreira (2003) defended that the pattern can be situated on the vertex of a triangle originates in the groupanalytic process, given that the other two vertices are: the group matrix and the internal relational matrix. I am in complete agreement and I would like to take this advantage to clarify this matter a little more.
It appears to me that the pattern allows one to open a door which connects with external reality. That is to say, insomuch as the pattern foments freedom of expression in the group, it provides space into where all the elements of the group reveal their vertices of observation, their capacities for empathic understanding and their modes of relating. The group matrix, being as it is, not only echoes the internal relational matrix of each one, but also provides a space of reality where the individual can practice the diverse aspects of the new restructured personality. I am referring to the concept proposed by Foulkes (1975) in *Ego Training in Action*.
I am of the opinion that the pattern offers, through the group matrix, an ideal training camp (Nava, 2003 b) where each element of the group can practice new forms of interpersonal relationship, and little by little can file down the unadapted aspects of his personality, of his self.

EMPATHY

The human capacity, so natural, to perceive the emotions, the feelings of others and to go and help them is usually called empathy.
Ickes (2003) nicknamed it metaphorically "every-day mind reading". The original German word *Einfühlung* means literally "to feel inside something" (Wispé, 1986). *Einfühlung* would result from a process in which the observer would project himself inside the perceived object.
Although various psychoanaçlytic authors, as for example Freud, Reike, Rogers, Melanie Klein, Bion ans Greenberg, have used and defined the term empathy. It was, however, Kohut who looked into the matter most deeply.
Kohut (1984) places great emphasis on the use of the empathic capacities of the analyst and affirms that although empathy is not created by the psychology of the self, he widens its application and gave it a deeper theoretical importance.
Kohut (1984) proposes the following definition of empathy: capacity to penetrate with thought and sentiment into the life of another person. Kohut defends that the only two tools on which the therapist can rely on to promote an analytic cure (transmutative internalization) are empathy and interpretation.
The neurosciences very recently have contributed towards clarifying the phenomena that are at the base of empathy.
Decety (Director of the Laboratory of Cognitive and Social Neurosciences of the University of Washington) and Jackson (neuropsychologist) (2004) begin from humanistic perspectives (empathy as innate ability) and psychodynamic
(empathy as the art of communication) and propose three fundamental components of empathy in human beings:
1. Affective Sharing between oneself and the other, based on the connection perception-action which brings about the shared representations.
2. Conscience of the ego and of the other. Even when there exists some temporary identification, there is no confusion
between the self and the other.
3. Mental flexibility in order to subjectively adopt the perspective of the other and regulatory *processes*.
These three components intertwine and should interact one with the other in order to produce the subjective experience of empathy.
Using this model as a starting point, I will try to imagine what takes place, in neurobiological terms, in a session of groupanalysis, when empathy is in action.
1) Using the model of perception-action, we know that there are representations shared between the emotions of the patient and the respective neuronal circuits of the analyst. That is to say, the emotion of the analisand is mirrored through *mirror neurons*, in the neuronal circuits which codify the same emotion as the analyst. This process is automatic, the analyst does not have to make any conscious effort, one just lets oneself go, without defending oneself. There is a natural and immediate affective sharing even before we have any consciousness of what is happening. This phenomenon corresponds certainly to one of the components, non conscious, at least until now, of the countertransference and is extremely rapid.
2) The second step is the consciousness of the ego and of the other, which ensures that there is a clear awareness of the limits and that there is no confusion between the analyst and the patient. It prevents emotional contagiousness, so that the analysts are not invaded by the emotion of the others, as if they were their own, something which, obviously would impede the therapeutic capacities to come into play. This level implies conscious processes, and as such, the training of the analyst as a person and a professional is very important.
3) Finally, mental flexibility allows the introduction of inhibiting mechanisms which slow down the perspective of the analyst (his referencial of life, based on implicit and explicit memories, somatic markers). At this point, regulating processes come into play in such a way that the analyst may assume the perspective of the other. This is the
part which can be altered most through the analyst's training where his thepretical training assumes greater importance.
This third component does not imply direct help, as Kohut said, we are not going to substitute directly the needs of the patient, the analyst will provide an explanation of these necessities.

Specific situations in groupanalysis

I believe that there is a series of situations which are characteristic of groupanalysis and which do not appear in dual therapies.

The possibility for the group to improve the empathic capacities of the therapist:

As Foulkes tells us (1975) one of the therapeutic factors of the group is resonance or mirroring. He refers/makes reference to the fact that the elements of the group mirror the emotions of the others through the phenomenon of shared representations, which is activated from automatic processes of perception-action. We know today (Preston, de Waal, 2002) that the similarity between people increases this process, and so the multiplication of this phenomenon
by the number of elements in the group increases the possibilities of finding more similarities and consequently of attaining greater empathy. Not to mention the cognitive dimensions of empathy which are also multiplied by the number of elements in the group thereby increasing even more this therapeutic capacity.
Bearing in mind all this data, it seems to me that resonance is a therapeutic factor, not only because it removes the blame from the others, and because it is easier to analyse in others (as Foulkes proposed) but because it greatly increases the capacity for analytic investigation. My clinical experience confirms that very often one of the elements of the group empathizes more with the patient in question or in a particular situation (which approximates more to his experience of life) and therefore possesses a greater capacity for investigation, collects more data, is more empathic than myself.
In practice, when I have difficulties in understanding a particular situation or what is happening to the group, I wait for the resonance of the others. Very often it is possible that his empathic capacity, increased by the motives already mentioned, enlightens me more about what is happening, therefore making it possible to widen/amplify my capacities of investigation and at this moment I can finally analyse and interpret with more differentiation what is taking place.
One of the questions I always think about when a patient enters a group is: what is this patient going to gain by joining a group of analysis. Even more so because it is a question that the patients themselves invariably ask.
I am of the opinion that when a patient enters a group, four new aspects arise:
1) Other dimensions of personality emerge in the relationship with the other elements of the group, which would not appear, if it was not indirectly through the accounts of the patients. All the phenomena which appear in the threeway
relationship appear freely in the group, without any defensive mask. The most common are: jealousy, envy, competition.
2) Other themes are now being talked about thanks to the phenomena of resonance and mirroring. In this way, the patient is brought to analyse particular aspects of his life which, on his own accord, he would never do and, which is forbidden for the analyst, for technical reasons, to force the patient into speaking about.
3) Other perspectives of empathic investigation arise and which are amplified by the other members of the group. This amplification allows the analyst to have a more complete image of the internal psychic world of the patient. In this sense, the other elements of the group may be considered co-therapists. I would like, however, to point out that it is only in this sense, what I mean by this is that, although other elements of the group might enlarge the capacity for empathic investigation, and sometimes, on levels more differentiated from the evolution of their analysis, might offer an empathic explanation, the responsibility and therapeutic obligation belongs totally and exclusively to the groupanalyst.
4) Bearing in mind the argument that social complexity was one of the driving forces of the evolution of the brain itself, we can assume that through the therapeutic process of the group (mini-society) the development of the brain continues to be stimulated. Admitting that the results of an analysis are transgenerational, they affect indirectly the children and lead to the evolution of the brain
5) The containing effect of the group which allows greater tolerance to the empathic errors of the groupanalyst. Simultaneously, this containing aspect is also fundamental until the process of transmutative internalization (that is, the creation of new neuronal circuits able to establish more adequate object relations) is complete, in a coherent form which allows the structure of the individual to be more autonomous in order to cope with external reality. Esta capacidade contentora do grupo fornece o tempo e o espaço para o *ego training in action* no campo de treino que é o grupo.

References

Ancona, Leonardo (1989). Matrix et pattern en analyse de groupe ou groupanalyse. *Grupanálise nº.4, Dezembro 1992*: 39-45
Brito, Etelvina (1989). O padrão grupanalítico. *Grupanálise nº.4, Dezembro 1992*: 7-22
Cortesão, Eduardo Luís (1988) *Grupanálise nº. 1 - Out. 1998*: 18-19
Cortesão, Eduardo Luís (1989). *Grupanálise - Teoria e Técnica*. Fundação Calouste Gulbenkian, Lisboa, 1989.
Decety, J.: Jackson, P (2004) The Functional Architecture of Human Empathy. *Behavioural and Cognitive Neurosciences Reviews.* Volume 3, Number 2, June 2004 pages 71-100.
Ferreira, G. (2003) *Para a construção de uma metateoria em grupanálise*. Comunicação apresentada em sessão científica da Sociedade Portuguesa de Grupanálise. Lisboa.
Filipe; E. C. (1989) Padrão grupanalítico. *Grupanálise nº.4, Dezembro 1992*: 23-38.
Foulkes, S. H. (1964). *Grupo-análise terapêutica*. Publicações Europa-América, 1964.
Foulkes, S. H. (1967). The concept of group matrix. *Group Analysis. 1:31-35*..
Foulkes, S. H. (1975). *Group Analytic Psychotherapy: Method and Principles.* Gordon and Breach. London.
Grotjahn, Martin (1985). Where did my hearing go? *Group-analysis, XVIII, 3, December 1985.*
Grotjanhn, Martin (1987). How much of an actor is a group analyst allowed to be? *Group-analysis, vol. 20, nº2, June, 1987.*
Guntrip, Harry (1977). Mon expérience de l'analyse avec Fairbairn et Winnicott. *Nouvelle revue de Psychanalyse, nº.15, Printemps, 1977.*
Hopper, Earl (1982). Group-analysis: the problem of context. *Group-analysis, XV, 2, 1982.*

Ickes, W. (2003) *Everyday mind reading*. New York: Prometheus
Kohut, Heinz (1984). *How does analysis cure?* The University of Chicago Press, 1984.
Leal, Maria Rita Mendes (1969). Transfert analytique dans l'analyse de groupe. *Bulletin de Psychologie, 295, XXIII*, *1969-70:*13-16.
Lear, Terence (1985). The inspiring role of the conductor. *Group-analysis, XVIII, 12, 1985*:150-154.
Nava, A.S. (2003 a) *O cérebro apanhado em flagrante*. Climepsi. Lisboa
Nava, A.S. (2003 b) O inconsciente e grupanálise. Poder ir mais além. *Grupanaliseonline.pt*, vol.1, 37-42.
Neto, I. (1999) *O Padrão – A importância do grupanalista na Grupanálise*. Comunicação apresentada no X Congresso Brasileiro de Psicoterapia Analítica de Grupo.V Encontro Luso-Brasileiro de Grupanálise e Psicoterapia Analítica de Grupo, Rio de Janeiro, Novembro de 1999
Pines, M. (1998) *Circular Reflections*. International Library of Group Analysis.
Preston, S. D.: & de Waal, F.B.M. (2002) Empathy: Its ultimate and Proximate Bases. *Behavioural and Brain Sciences,* 25, 1-72.
Racker, Heinrich (1988). *Estudos sobre Técnica Psicanalítica*. Artmed. Porto Alegre, 1988.
Stern, D. et al (1998) "Non Interpretative Mechanisms in Psychoanalytic Therapy – The Something More Than Interpretation". *Int. J. Psycho-Analysis*. October 1998. Volume79, Part 5: 903-921.
Wispé, L. (1986) The distinction between sympathy and empathy: To call forth a concept a word is needed. *Journal of Personality & Social Psychology* 50: 314-321.
Zimermann, D. (2000) *Fundamentos Básicos das Grupoterapias*. Artmed. Porto Alegre Brasil.

Carla Penna
Clinical Psychologist;
Psychoanalyst of the Psychoanalytic Circle, Rio de Janeiro;
Former-President of the Brazilian Group Analytic Psychotherapy Society (2004-2006);
President of the Brazilian Group Analytic Psychotherapy Society
Rio de Janeiro
carlapenna@ig.com.br

Commentaries to Ana Sofia Nava's paper: Pattern / Matrix / Group Analytic Process / Empathy

Since Bion and Foulkes in the English school and Anzieu and Kaës in the French school, very little has been produced in terms of group theories. Melo Franco (2003) says that group theories have suffered a kind of orphanhood due to Bion's early abandonment of his scientific work with groups. Some suggest that it was because of the opposition he had to face on the part of the British Society, and especially of Melanie Klein. "*This death, which has not been adequately explained, may have left its marks on the group of analysts interested in PAG*". According to Ponciano (1995) Foulkes himself, following his reading at the London Psychoanalytic Society, of the article "On Introjection" was given the cold-shoulder by Klein's friends, Jones e Rickman, and little by little distanced himself from their theoretical positions. In 1952, Foulkes founded in London the "Group-Analytic Society", being the initiator and founder of the technique of group psychotherapy of groupanalysis.

Eduardo Luis Cortesão was a brilliant disciple of Foulkes and brought to Portugal a solid framework which led to the organization of the Groupanalytic Study Group, in 1956, evolving into the Groupanalysis Session of the Portuguese Society of Neurology and Psychiatry in 1963, until the creation of the Portuguese Groupanalytic Society, in 1981, as we see it today. The work progressed with competence and technical rigour, into the second and third generation of the supporters of Cortesão. I believe that much of this Portuguese vitality is due to the constant presence and the containing influence of Cortesão, as master and trainer of groupanalysts. It should be said that in terms of technical enrichment, it was Portugal that gave us new concepts such as **pattern** from Cortesão and **internal relational matrix** from Maria Rita Leal. At the vertex/apex of the triangle of the groupanalytic process, as Guilherme Ferreira points out (2001), we have the group matrix of Foulkes. The interaction between the three entities could/ should resolve the transference neurosis that each of the members develops during groupanalysis.

In Brazil, in 1951, in what was then the National Service of Mental Health, now called the Federal University of Rio de Janeiro, Alcyon Baer Bahia held the first analytic group. Following this experience, doctors and psychoanalysts
interested in the study of groups, an activity forbidden within IPA, organized from 1958, Societies of Group Analytic Psychotherapy, in Rio de Janeiro, São Paulo and Porto Alegre. The first and second generation had a strong influence in clinical terms until the period of the military dictatorship and in the 80s when there was a decline of group activity in consultations. In the institutions homogeneous and somatic groups proliferated and the theoretical pronouncements were enriched by the contributions of David Zimerman based on Bion and of Júlio Mello Filho based on Winnicott, both second generation, among us.

In Argentina analytic groups remained active for several decades. Here, the main exponents were Grimberg, Langer and Rodrigué until from the beginning of the 70s and from the period of the military dictatorship, when there was an exodus of analysts and group work declined. Quoting Melo Franco (2003) *"unexplained deaths lead to pathological mourning. In the case of the PAG, this special mourning was translated into a situation of scientific orphanhood,*

which, if it is not experienced consciously, left marks, above all in the conceptual evolution which the instrument needed."

In spite of all the difficulties the work with groups resists and we have observed in the new generation the search for contributions from related sciences such as: sociology, the neurosciences, aetiology, the diverse psychologies and psychoanalysis itself. It is this strength and modernity that brings us to Ana Sofia Nava. The author presents theoretical-clinical paper, consistent and original, explaining concepts which are well founded within the tradition of Portuguese groupanalysis, while still subjecting them to sensitive criticism and new ideas.

She uses the concept of pattern, of Cortesão, which is not used in Brazil, in order to situate the groupanalyst in relation to his functions, activities and attitudes as therapist. For us, the author values, taking into consideration her research into empathy, what we call the person of the analyst: his training, his theoretical knowledge and his way of being in the group and the way he manages the transferences and counter transferences. Basically, she emphasises how

the presence and action of the analyst is transforming. For her, the group matrix, Foulkes' concept, is the heart of the group, the way in which communication takes place and the cohesion between its members. The internal relational matrix, a term also not used in Brazil but brilliantly captured by Maria Rita Leal, gets right to the centre of the treatment, in that it reactualises, in the groupanalytic process, archaic models of relating, incorporated by the individual, in early infancy and within the family circle.

In the groupanalytic process, Ana Sofia Nava emphasises the importance of pattern in that it permits the opening of a connection between the group and external reality. During the session, the components of the groups can express freely their internal anxieties, actualized in the group relationship, as well as observing along various vertices their modes of relating. The group matrix, echoing in the internal relational matrix, enables each member to recreate the original family space in a more careful way and fundamentally diverse from that which they experienced. The patients

may then: "*try out new forms of affective relationship within the new family, which is the group" (Nava/Foulkes).*

As nerve centre of her reflections, she presents the concept of empathy, not only in the sense as understood by Kohut, but considering the psychoanalytic contributions of Eagle and Wolitzky, Stolorow and David Stern. Furthermore,

she makes use of aetiology, of the neurosciences and cognitive psychology in order to bring up to date and enrich her research. "*In my clinical practice, empathy is always present and, in some way, I had the feeling that studying this*

topic in depth would bring practical benefits, in the sense that this would allow us to explore, amplify and perfect groupanalytic

technique"(Nava 2005). The importance of empathy in groupanalysis for the author goes far beyond common sense. The use of empathy, allied to the Neurosciences, revealed for this groupanalyst the modernity of the **mirror neuron**, while continuing to adhere to the importance of the traditional mother-baby relationship of psychoanalysis. At the present time, where patients increasingly present narcissistic and corporal pathologies, the result of severe empathic failures from the very beginning of their development, the empathic capacity of the analyst becomes an increasing requirement. Groupanalytic work carries in its centre the possibility of creating/recreating in the group setting a place of profound empathy, a potential space, as Winnicott would describe it, where the patient can constitute or reinvent himself, transforming the unswayable into representation and the non experience into one which is satisfactory

and shared.

Ana Sofia believes that the "*creation of the self is established in the relationship with others, through an equilibrium between external and internal reality*" and postulates the sessions of groupanalysis constitute an extraordinary training

field for the creation of new equilibriums. And adds to what is traditionally conceived in terms of Foulkes' conception

of **ego-training in action**, novel contributions departing from the Neurosciences in postulating that it makes possible for the patient in being confronted with the reality brought by other members of the group the "*creation of a new equilibrium through the sedimentation of implicit memories, in new circuits of relational patterns."*

Despite different nomenclatures and even diverse theoretical lines of thought, the Portuguese and the Brazilians speak the same language, with different accents sometimes incomprehensible. Groupanalysis or Group Analytic Psychotherapy, offer to the patients a profound form of relationship which transforms the manner in which they relate to the world. The crossed transferences, repeating and up-dating past relationships, group exchanges, confidence

in the figure of the analyst on whom are projected good and bad objects, received and translated in an empathic and digestible form are fundamental. The support, shared representations, discrimination between what is mine and what is of the other, the group atmosphere, the internal relational matrix, up-dated in the groupanalytic process, and above all the experience itself lived in the heart of the group, speak for themselves, in any continent.

I would like to add, that fruit of my own theoretical reflections, that what Ana Sofia Nava attributes to empathy in groupanalysis, which is responsible for that which exists most in terms of truth and depth in human relationships, can be translated into what I would call the identification that the group promotes. With the passing of time, I believe more strongly that the wealth of the group experience is that it permits in the analytic setting, the construction of primary identifications for some and more consistent secondary identifications for others. But this is a theme for later discussion...

References

Melo Franco, O.(2003) *Primórdios: Psicoterapia Analítica de grupo - A Trajetória de uma Idéia e de uma Práxis.* in

Grupos e Configurações Vinculares, Fernandes&Fernandes Artmed ed. Porto Alegre.
Nava, A. (2003) *O Cérebro Apanhado em Flagrante*. Climepsi, Lisboa.
Nava, A. (2006) *Empatia e grupanálise: uma abordagem integradora*. Climepsi, Lisboa
Ponciano, J. (1995) *Psicoterapia de Grupo Analítico*. Casa do Psicólogo.
Salgado, F. & Pinto, T. (2001) História da Grupanálise em Portugal: 1º parte, in *Revista Portuguesa de Grupanálise v., 52-71, Fim de Século, 2001*

Júlio de Mello Filho
Psychiatrist;
Professor from the Medical Psychology
Department, Medicine Faculty,
Rio de Janeiro University;
Member of the Brazilian
Psychoanalytic Society from
Rio de Janeiro;
Former-President of the Medical
Psychosomatic Brazilian Association
juliodemellofilho@terra.com.br
(1) Probably when the rage has already passed and the confusion can be discussed with more tranquillity.

On the Management of the Counter Transference in Group Analytic Psychotherapy

The theme of counter transference has always fascinated me. It is the way the analyst participates in a real living way, through his emotions, in the analysis of his patients. This gives him an altogether special sentiment, of veracity, in a two-way, eight-way authentic process of that analysis, of that interaction.
As we all know the term was introduced by Freud to designate the sentiments and emotions of the therapist, mostly unconscious, which arise in response to the transference of the patient. For Freud, the counter transference was a condition generally pathological, one of blocking interaction, since it was based fundamentally on unconscious phenomena on the part of the analyst and, therefore, inaccessible to the ongoing process
Paula Heiman, in 1950, widened considerably this concept in demonstrating how the perception of the counter transference could be utilised in relation to what was happening to the patient and this could be included in the interpretations of the therapist enlarging considerably the field of *insight* lived through by the duo/double/pair. However, as with Freud, in his work, the counter transference was not acknowledged by the patient, but remained within the internal world of the analyst. It was like a radar, capturing the deepest vibrations of the patient communicated
to him without reference to what was happening to the analyst.
In 1947, Winnicott published a notable work called, “Hate in the counter transference”, in which he described three types of counter transferencial phenomena:
1) Stereotyped relationships and certain identifications repressed inside the analyst “Meaning that the analyst needs more analysis”.;
2) Identifications and tendencies which form a part of the experiences and personal development of the analyst and which make his work different from that of any other analyst (normal counter transference);
3) True and objective counter transference, that is to say, the analyst’s love and hate as a reaction to the real personality and behaviour of the patient.
In this work he affirmed that in the analysis of psychotics it was common for the analyst to feel hate for the patient. These patients were *experts* in provoking hate and that only through objective hate could they reach objective love which they had a right to. “I would like to add that in certain stages of certain analysis, the hate of the analyst is searched for by the patient and, in this case, objective hate becomes necessary”. For him, this situation is common in the analysis of psychotics and also in patients with an anti-social tendency.
He also said that in most cases, such a situation should be kept to be exposed, admitted at a later date.[1] Winnicott gave us the example of a serious obsessive with whom, close to being discharged, he was able to admit how “abominable” the patient had been for many years for him and for many friends, although he was not, in those moments, conscious of it.
To justify his affirmations even further he gives us the example of mothers who hate their children even before they are born and afterwards for having to do all the “dirty work” who are subjected to so many frustrations and deceptions regarding the son she idealised so much.
When I first initiated my analytic training, I had a manic-depressive patient in individual analysis, who, on one occasion, in a phase of mania, took off all his clothes, at night in the middle of Copacabana beach and went for a swim
in the sea, causing distress to people walking along the beach. I interned the patient and accepted his behaviour as part of his pathology.
On another occasion, however, when he was better and living with his mother, he deflowered one of her friends who had just had plastic surgery on her hymen. He told her, in a rage that what he would like to do was to have intercourse with his mother and that he was acting out to show all his hate for women. The patient noticed my anger and questioned me about it. I admitted that it was difficult to tolerate his treatment because of all the deceptions he had caused me. This incident was worked through positively to the benefit of his analysis, which came to a

satisfactory conclusion, and the patient had no more psychotic attacks.
In another work, equally revolutionary, “Clinical forms of counter transference”, he affirms that certain patients, serious cases, often use the errors of the analyst and that it is more prejudicial to commit errors with in the analysis of neurotic patients than with these patients. He says that this is because, in these cases, an important part of the analysis takes place inside the analyst, hitting directly his *self*, say I, his defences, his id, his sentiments, his self-esteem.
The most important thing in such a situation, continues Winnicott, is that the errors of the present always refer to errors of the past, of the basic figures, the mother, the father, the facilitating atmosphere. And so, for this reason, through the mistakes and bad adaptations of the analyst, induced by his anger and uncontrolled emotions, the patient will experience mutative situations (Strachey) or, I would add, corrective emotional experiences (Alexander).
In human therapeutic groups, principal in analytic groups, aggressive situations usually occur in function of the vis-à-vis of the therapy itself, favouring frontal aggressions between members and between these and the therapists, sometimes leading to aggressive replies from the latter.
In 1986, writing in the now classic book of Luiz Carlos Osório “Grouptherapy Today” the chapter on “The Contributions of the Winnicottian School to grouptherapy” I stated that:
In the group we are often put to the test – head on. The patients hurt us face to face and the group aggressiveness experiences/experiments frequent increases in situations of jealousy, envy or rivalry felt directly by the participants between themselves or in relation to the therapist. The face to face and the immersion of the group as a whole leads us sometimes to give direct replies, to reply in kind without an opportunity to think and reflect. All this is facilitated by the regressive climate in which many sessions take place. The multiplicity of participants and processes of interaction favours our being hurt by projective identifications, without the perspective of recognising the source and the why of sentiments of frustration, irritation or rejection which are aroused in us. All this may lead us to feel guilty, or wound our Professional self-esteem. We may feel we are excessively aggressive and even lead us to give up from this
type of group therapy. Furthermore, when our omnipotence does not help us to admit, like Winnicott, that hate is part of the analytic process and that there are patients who only through our errors manage to make real progress”.
The perception of the group of our aggressive sentiments is a fact: tone of voice, posture, vasomotor reactions, etc. Today, when I express my irritability and nobody points this out I always question the group about it. The most important thing is not the aggressiveness of the therapist in itself, but the therapeutic use that can be made from this fact. The therapist who does not admit to sentiments that that he has just expressed is, in reality, trying to indoctrinate the group, treating it like the child who must not argue or criticise the reactions and attitudes of a father (or mother), all-powerful and superior.
One of the situations which arises most in a therapeutic group is jealousy and this is generally accompanied by intense rage which is directed at the couple towards whom one is jealous. This is what happened in one of my groups in which two patients were at odds for my preference. One of them, Sonia, was born in the same town as myself, was from a medical family and was the eldest of five brothers and sisters. I came from a similar family and while she as her
father’s favourite I was my mother’s. Both families were well-known in the social circles of Recife. The other, Ângela,
also a doctor, came from a family of three brothers and sisters and was also her father’s favourite.
Sonia suffered from endometritis and had constant attacks of intense gynaecological colic. She was also suffering from an unsatisfactory relationship with a married doctor which she managed to put an end to in the course of the treatment. Because of all this she made many demands on me as therapist. She was for me a special patient and I tried to minimize this context faced with the jealousy of the group, principally from Ângela. There came a time, however, in the course of an aggressive pique of the latter, that I revealed the situation to the group and showed them the similarity of our family contexts. I said she was in fact a special patient but that they were all special since they were patients in my first group, a group close to my heart and that there were there other special patients as well: Carlos, my first group patient, Roberto, for being the great painter that he was, Ângela, for the complete doctor that she is in body (nephrologist) and in mind of the patients. The elaboration of the question of jealousy which took place after this session led to a release in tension of this subject in the group and to a playing down in the rivalry between the two
doctors as well as regarding the jealousy.
A very seductive young woman, with traces of mania and hysteria, attended two periods of group psychotherapy with me. In the first phase, she sought help principally because of intense conflicts with her husband, both being narcissistic and explosive. She was very attached to her father who was clearly jealous of the husband and contributed actively, playing one against the other, to the deterioration of the marriage. On the point of separation, at an opportune moment, she became involved in a sexual relationship with a friend of her father. She was questioned by the group about the impropriety of the relationship which, inclusively, would complicate the marriage separation that she was managing in a less than stable way. I believe that I interpreted adequately the situation, focussing on, among other things, on the displaced incestuous relationship with the father onto his friend and the attempt to make me jealous as retaliation for my forthcoming holidays that she was showing signs of not looking forward to. However,
- it was only later that I understood -, I acted as father protector, assuming the support that the true father was not giving her, putting pressure on her with my interpretations not to involve herself in the extramarital relationship. Thinking that I and the group wished to dominate her with our interventions, she abandoned the treatment.
She returned a year later, now separated but feeling depressed and isolated with few perspectives for existential realization. During this second phase of treatment, following initially a number of improvements in psychosomatic

reactions connected to her depressive syndrome, she fell into a phase of apparent schizoid withdrawal. with very little participation in the group. To my total surprise and to that of the group, one of her colleagues explained, full of guilt that
he had been having sexual relations with the patient for quite some time. She simply admitted the fact, in a rather cold way, without showing any regret. My reaction was one of rage which I transmitted focussing on their insincerity and the
attempt to break the group compromise. Following more reflection on my counter transference, I admitted my anger in front of the group, for having felt like a father betrayed by two children who were having an incestuous relationship.
I was also able to recognise that if the patient tried once more to make me jealous, this would create, at the same time, a possibility to correct myself for the mistake I had made years before which had contributed to her leaving the group, and so giving me an opportunity, now, to act like a father who was not excessively involved with her, i.e. firm and imposing limits. In this way, I was able to offer her a different image of the father who had not been able to play this role
in her whole life. From that moment onwards, the situation was sufficiently worked through, allowing the incestuous intergroupal link to dissolve and enabling to proceed with the treatment of the patient with results.
The possibility of being aggressive and later to show myself/confess was important for the two patients since it enabled them to evaluate the severity of the *acting out* they were committing: it was also useful for the young man, in the sense of coping with the aggressiveness of a paternal figure, because as regards the authoritarianism of his own father he was simply terrorized and without reaction.
Adriana is an asthmatic patient, married, in a profession similar to mine. She also comes from a family from Pernambuco. She is a very aggressive person internally, but with difficulties in exteriorising and admitting her aggressiveness. In his group there were also other patients with this behaviour. On one particular occasion Adriana came to realize that when I moved, I pushed the analyst's stool with my feet. And she said: "Dr. Julio is annoyed, he's
fed up with life, and kicked the stool". At first I said nothing but then later admitted: "That's quite correct, it's what so-and-so said (or did) that made me angry, upset and annoyed".
Adriana's behaviour changed now that she could better express her aggressiveness; the asthma stopped. She was now able to express all the affect and admiration she felt for me and which was contained (bottled up).
The phenomenon of the stool helped her considerably insomuch as she could now elaborate the question of the aggressiveness of the father and mine, ostensive in relation to her, frightening and occult. She could also see that I and
her father were two completely different people and the *acting in* (therapeutic) of exhibiting my aggressiveness disappeared as, over time, I didn't need to unmask myself anymore.
People who complain of having had very aggressive parents frequently provoke the therapist, and with more than a little success, into acting aggressively towards them. In doing this, they try to repeat unendingly this type of conflicting situation. However, at the same time, they give to the atmosphere an opportunity, represented by the analysis to self correct, to modify themselves, through an answer different from that given by the parents. If the therapist acts from the beginning aggressively, but with the profound perception of his counter transference understands
what is happening and, in analysing the situation, acts in a novel and different way; this contributes towards the progressive resolution of the conflictive nucleus. The presence of the group, on the one hand, is a stimulus for the patient to "dethrone" the analyst, demonstrating publicly, by example, how any figure of authority acts arbitrarily. On the other hand, however, when the therapist interprets adequately the situation, this enables the group, from the *insight* obtained, to act as an auxiliary therapeutic form.
Those who have images of very omnipotent parents, who never admit to mistakes, need, compulsively, the therapist to fail, acting inadequately, with aggressiveness, making mistakes in interpretation, committing errors and forgetting things. In these cases, the simple admission of failure by the analyst already acts therapeutically on these patients. The important thing is the humility of the analyst who, in admitting that he functions like a normal human being, affords to the patient a different experience.
This situation, in which people need to have very concrete experiences in order for them to modify themselves can be very difficult and tiring for us, as therapists. After all, as Winnicott once wrote, we are not the real parents of our patients... But we need to have a lot of persistence because, as he himself tells us, there are patients "in whom part of the analysis takes place inside the analyst himself ", with a participation full of all his emotions.
On occasion this type of situation is mitigated by the participation of the group collaborating with the therapist. There are occasions, however, in which the group is not sufficiently integrated, in which it is depressed, or agrees with the aggressive behaviour of the patient and in which it is up to the therapist to accomplish a more difficult task. I remember a particular patient, a specialist in picking an argument with me, to whom, on a particular occasion, I expressed my despondency in helping him to overcome this situation. My testimony was exactly the perspective of our being able to understand how he had provoked this type of sentiment in his father and in various other people, of importance for him, with whom he lived.
There are patients who need to learn that the experience of aggressiveness does not provoke total destruction, that it is a human condition with a possible solution. Sometimes, the whole group needs to learn this experience. In a group
in which schizoid and depressed patients predominated, I needed to teach them what Winnicott called "having consistency". One of the necessary conditions for this was to be able to be aggressive in certain occasions. This was multiplied, however, numerous times because the group, in an attitude of envy and rivalry, needed to prove to me that

there was no consistency, on my part and yes, exaggerated aggressiveness. This is a warning to our need to be sincere,
authentic and, if necessary, even aggressive. Not to transform this aim into a wearing down, masochistic behaviour, in the
service of a sadistic, competitive side, hidden in the behaviour of the patient or of the group before us.
On the other hand, I believe it is important to emphasise that these moments are not routine in group work, but significant instances in which arises the need to elaborate the problem of group aggressiveness, shared by the therapist
through the truth of his counter transferencial sentiments.

References

Heimann, P. (1987) Sobre a contra-transferência. SBPRJ. Boletim Científico, Rio de Janeiro, v.1, n.4, p.104-1109, 1987.
Little, M. (1951) Countertransference and the patient´s response to it. The International Journal of Psycho-Analysis, London, v.32, p.32-40, 1951.
Mello Filho, J. (1986) Contribuições de Winnicott à psicoterapia analítica grupal. In: OSORIO, L. C. Grupoterapia hoje. Porto Alegre: Artes Médicas.
Racker, H. (1982) Estudos sobre técnica psicanalítica. Porto Alegre: Artes Médicas.
Winnicott, D. W. (2000) Formas clínicas da transferência (1955). In: Da pediatria à psicanálise. Rio de Janeiro: Imago.
_____ (2000) O ódio na contratransferência (1947). In:. Da pediatria à psicanálise. Rio de Janeiro: Imago, 2000.

Cláudio Moraes Sarmento
Psychiatrist;
Full Member of the Portuguese
Group Analytic Society;
Full Member of the Group Analytic
Society London
clinicatagide@netcabo.pt

Comments to Júlio de Mello Filho's paper: On the Management of the Counter Transference in Group Analytic Psychotherapy

It is a great honour to be asked to comment on someone as important as Dr Júlio de Mello Filho.
We are today more than colleagues, friends, since our personal relationship has been fuelled and deepened through our regular Luso-Brazilian meetings.
I feel it a great responsibility but also a great pleasure to have the opportunity to make these comments.
I shall make some references to some of the formal aspects of the paper and also some questions on the content.
I am sure it will be a contribution which will stimulate debate around a constructive comparison of the work done between Portugal and Brazil, with
regards to group-analysis or individual group analytic psycho-therapy.
Regarding form, we have before us once again the clear and succinct way that is a hallmark of Júlio de Mello's communications. It is a fact, though, that to be so clear, concise
and didactic can only come from someone with immense experience and a vast volume of work already developed.
As a visual counterpoint, this reminds me of the drawings of Picasso and their apparent simplicity which he only attained at the age of 60. When asked about the speed with which he did his sketches, Picasso said- you only need paper and pencil and 60 years of work.
The ability to transmit concepts such as counter-transference is complex and difficult since it may expose the analyst, who habitually remains safe within the therapeutic setting.
Júlio de Mello Filho shows in this talk a calm courage in going into clinical cases from his own professional activity (something I have already witnessed, for example, in his conference presented a year ago in Portugal entitled «Working with groups». He did not feel inhibited in revealing counter-transferencial reactions, in this presentation which reveals so much about his true way of being in his clinical work.
He combines the apparent simplicity and the richness of complementing a paper imbued with profound theoretical concepts with clear clinical examples.
Regarding the content: he looks above all at authors such as Freud and Winnicott. I will have recourse later to the comments on Bion, Zimerman, Racker and Grinberg. .
Freud makes the first reference to the term counter transference in a letter to Jung concerning the difficulties he is feeling as regards a patient. But he always considered the counter-transference as a difficulty and source of disturbance that the analyst must recognise and dominate. He believed that the psychoanalyst should only reflect on that which the patient shows. But this may rely on the phobic aspects of Freud and might have conditioned his standpoint in the setting which was outside the angle of vision of the patients.
In the group we see. We look in front, we have the mirrors of the eyes before us.
Júlio de Mello alludes to something that is unique in group analysis, at least when compared to psychoanalysis, and that is the importance that vision assumes in the whole process.
It is not by accident that in group analysis we look, in fact, Foulkes took a course in architecture and had a memory which was particularly visual (according to what his wife Elisabeth Foulkes wrote). This aspect of the

personality of the founder of group analysis must have also had a decisive influence (as it did with Freud) on the whole
course of group therapies.
In fact, when Júlio de Mello tells us that in the groups there exists the perception of all our aggressive sentiments, and that when this is not commented on, he questions the situation directly, he is also making use of this weapon which is vision. The same situation occurs with the episode of the foot stool – "The Doctor is fed up with all this" says Adriana when she sees the footstool shaking.
Júlio refers to the important fact that there exists the perception of the analyst's counter-transferencial reactions by the group. They are seen by them. The situation in which the group can become constituted as container for the analyst's content (Bion).
In fact, Bion approaches the transferencial counter-transferencial phenomenon by means of his model of container-content interaction.
The group element can function, at times, as an element of examination of our own counter-transference. One cannot have recourse to it directly, but this does not invalidate the fact that we must be aware of its dimension. Added to the fact that it does not make sense to approach the counter-transference outside the binome transferencecounter-transference, a binome both dialectic and dynamic, one must be attentive to lateral transferences, activated among other elements of the group. One important aspect (César Dinis, 1994) is that it is up to the analyst to capture in his counter-transference the lateral transferences, towards other elements of the group instead of the analyst, and through interpretation returns them to their authentic path.
One aspect which has been problematic in the history of psychoanalysis is knowing whether the countertransference is a uniquely unconscious phenomenon or also conscious (which I also believe it to be) and the
possibility of its being used in a beneficial, inadequate or even iatrogenic way.
At the present time, there predominates between psychoanalytic authors a triple dimension of counter-transference.
1. As an obstacle
2. As a technical instrument
3. As a work space in which the patient can relive the original emotional experiences.
The more regressed the patients, the more important the counter-transferencial scrutiny. In the clinical illustrations of Júlio de Mello we have good examples of how they may be used advantageously. In the case of the patient who returned years later, a second opportunity (which should be underlined since it only existed through the quality of the relationship previously established in the binome transference-counter-transference), which allowed in the time a reparation which might have been an actuation in the counter-transference of massive projections , so the analyst transmitted.
In the case of Ângela which was mentioned, I believe that there might have existed what Racker (1973) describes as counter transferencial reaction of a complementary type in which the analyst is identified with internal objects of the patient, *(in opposition to the counter transferencial reaction of the type concordant- identification parts of the patient)* the
paternal imago who was a doctor and family member and well-known in the society circles of Recife, identified with the imago of the mother of the analyst.
Júlio de Mello gives us examples of these last two situations. But later reveals how this complementary countertransference
can be transformed into empathy or concordant counter-transference
When the young seductive woman gets involved with the father's friend, Júlio de Mello acts as he said, in reply to the projective identifications coming from the patient and which provoked in the analyst a reaction of projective counter identification (concept of Grinberg (1963). That is to say, it was not the particular conflicts of Júlio de Mello which determined the counter-transferencial reply, but quite the reverse, he was overwhelmed with the massive charges of the patient's projective identifications and, as he said, he came to play the part of the patient's father.
The situation is repeated when years later when he returns to treatment and becomes involved with a fellow patient in analysis He attempts to lead the therapist into carrying out the role of betrayed father. And once again we see the fruit of a massive charge of projective identification. However, through a counter-transferencial examination, and using it as a working tool and field of analysis, Júlio substituted the interpretations through an attitude of containment, (firm and with reassuring limits). By not having assumed the role induced by the patient, permitted the experiencing of a new corrective emotional experience (Alexander, 1946; Jacobs, 1990). Feeding the conflict would probably lead to the compulsion for repetition, through the reinforcing element of the internal object – the father, and the patient would abandon treatment yet again. Rosenfeld describes this situation in an article entitled «The Psychosis of transference» (1978).
It is a prime example of what Bion describes as *apprenticeship with experience* (Bion's terminology*)*. The process by which counter-transferencial reactions can be transformed is described by D. Zimerman (2004) as an *empathic compass* within the session.
As a final note to the commentary on this presentation I would underline the importance of the aspects of the character and training of the analyst. The need for him to be authentic and sincere, as Júlio describes and I would like to make give special reference to the importance of the process of analysis of the analyst which should be as complete as is possible, avoiding as far as possible the blind areas, which implies time and training, as well as accompanied supervision, in order to be able to safely separate what is counter-transference and not transference of the analyst.
In this last example neurotic conflicts of the analyst might be confused with counter-transference and be transferred to the patient.
If a certain patient sets off in another analyst an emotional reply of the kind similar to-counter-transference. On the other hand, if a certain analyst has the same emotional reaction towards patients with n analogous psychic

structure, then it is the analyst is the source of these sentiments.

I would like to thank Dr Júlio de Mello Filho for sharing this experience and knowledge and to everyone here for the opportunity to make these brief remarks which I hope the audience will find stimulating.

References

Alexander, F.; French, T., (1946) *Psychoanalytic Therapy, Principles and Applications*, New York: Ronald Press.

Dinis, C.(2000) Desejo e perda na Contra-transferência, *Revista Portuguesa de Grupanálise, nº 1 Fim de Século, pag-51-58, 2000.*

Grinberg, L. (1963) Psicopatologia de la identificatión y de la contraidentificación protectivas y de la contratransferencia.
Rev de Psicanalisis, V20, n.2, p113, 1963

Jacobs, T.(1990) The Corrective Emotional Experience: It's Place in Current Technique, *Psychoanalytic Inquiry*, 10, 1990: 433-545.

Racker, H. (1973) *Estudios sobre técnica psicanalitica*. Buenos Aires: Paidós, 1973.

Rosenfeld, H.(1989) A psicose de transferência no paciente fronteiriço. Ver. Brasil. *Psicanál. V23, n.3, 1989.*

Zimerman, D. (2004) *Manual de técnica psicanalítica, uma revisão*.. Porto Alegre, 2004.