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Group Psychotherapy of Psychosomatic Outpatients – Analysis of the Ten First Sessions

Lazslo Antonio Ávila
Faculdade de Medicina de São José do Rio Preto (Brazil)

This work presents a description of a psychotherapeutic group of psychosomatic patients conducted in an out-patient setting. We show the gains of insight in the group's organization and inter-personal communication, as well as the relief of symptoms in seven patients attended by this psychoanalytically oriented group therapy. We discuss the extent and the limits of the group technique for such patients and we conclude with some proposals about the efficacy of this therapeutic approach.
Keywords: psychoanalysis, psychosomatics, groups, psychotherapy

Este trabajo presenta la descripción de un grupo psicoterapéutico de pacientes psicosomáticos llevado a cabo en un entorno ambulatorio. Mostramos las ganancias de "insight" en la organización y la comunicación interpersonal del grupo, además del alivio de síntomas en siete pacientes atendidos por esta terapia de grupo de orientación psicoanalítica. Comentamos la extensión y los límites de la técnica grupal para estos pacientes y concluimos con unas propuestas acerca de la eficacia de este enfoque terapéutico.
Palabras clave: psicoanálisis, psicosomáticos, grupos, psicoterapia

Correspondence concerning this article should be addressed to Lazslo Antonio Avila, Rua Saldanha Marinho, 3564, São José do Rio Preto, SP, Brazil, CEP 15014-300, e-mail: lazslo@terra.com.br

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In this paper we aim to describe in some detail the first 10 sessions of a psychotherapeutic group, conducted based on the psychoanalytical approach for group psychotherapy (Anzieu, 1987; Bach, 1972; Bion, 1970; Foulkes & Anthony, 1972; Käes, 1976, 1997; Pichon-Rivière, 1998). The group was composed of a psychotherapist, two observers and patients with psychosomatic symptoms, with therapy being conducted in the out-patients department of a public general hospital in Sao Paulo, Brazil.

The group setting is conceived as a space for the individual expression of members' singular histories. It is also an ambient where group phenomena occur; identifications, transferences and link processes can be acknowledged and translated. We understand the group as a privileged therapeutic space, inasmuch as it is within the group that the historical components of each member's subjectivity are updated by the very act of expression. It is in the links that psychical organization is accomplished; by interaction, the crossed identifications that sustain the elaboration of the individuals' identities will transit making them meaningful.

The basic proposal of this therapeutic group of psychosomatic patients seen in the out-patients department is to provide a setting where, from the beginning, there is recognition of the common nature of their symptoms. The group works as a special type of mirror, where participants are able to see themselves reflected in others organized around a common production axis. The model for the psychoanalytical understanding of symptoms in general, and also for psychosomatic symptoms, conceives them as a language, where what is expressed is the totality of the conflicts that are present in the interior of each psychic apparatus. If the symptom is a translation, then the group becomes the ambient for reciprocal translation. The therapist has the role of collecting the expressions of each patient emerging from the interactions among group participants, searching for unconscious determinants that struggle to be expressed and find their symptomatic path in the suffering body.

The therapeutic group is guided towards the verbal dimension, inhibiting the manifestation of actions and behavior discharges, as these, in general, are considered substitutes for the elaboration process (acting out). The group is, therefore, stimulated to speak, discuss and to interact. It is from the whole set of links and interactions of the group discourse, that the therapist searches for the elements that can explain the individual and group aspects that constitute the psychical life of the participants and, especially, the symptomatization process specific to each subject.

On many occasions, psychosomatic symptoms may function as body symbols, as was proposed by Georg Groddeck (1984, 1992) and Joyce McDougall (1991). These authors defended the concept that there is comprehension of symbols in psychosomatics; the psychotherapeutic work with these patients is similar to any other form of psychotherapy. On the other hand, the authors of the Paris Psychosomatic School, such as Pierre Marty (1994), consider that there is a process of *dementalization* in the psychosomatic symptom, due to a failure at the preconscious level during the building of preconscious representations that leads to changes in the technique to be adopted. Maybe the therapeutic group can be an intermediate element, allowing the articulation of both these dimensions. Zimerman (1995) said that internal links are reproduced in the interpersonal interactions as a dramatization in the scenario of the outside world, just as a theater play. Equally, aspects of the external world can also be repeated inwards as link configurations of the internal world. The author describes the group situation as a "hall of mirrors". Psychosomatic symptoms, in this location, might be mutually interpreted, and group members will help each other to better understand the meaning that his/her symptoms, translated in the body, have in the psychical sphere.

The group-analytical approach known as *psychoanalysis of the link configurations* (Bernard et al., 1995; Fernandes, Svartman, & Fernandes, 2003; Puget & Berenstein, 1994) is a powerful instrument in clinical work, expanding the possibilities that have been explored by the aforementioned psychoanalytical authors, particularly in respect to some insights derived from *operative groups* (Pichon-Rivière, 1998). The notion of an unconscious structure produced by the subject-object relationship, summed with the dimension of the link between them, allows a new comprehension of the group phenomena beyond inter-subjectivity. A further search for unconscious determinants that form the structure of the psychic apparatus from trans-subjectivity, articulates the psychism in its own constitution. At this level psychosomatic phenomena are connected in the matrix where the psychical and the physical components are indistinguishable (Bion, 1970). This is where it becomes possible to construct interpretations, favored by the group context, and efficient in the transformation of psychosomatic symptoms (Ávila, 2004, 2005).

Method

Our methodological option is to present here the first ten sessions of this psychotherapeutic group, as they clearly illustrate two of the main processes in all group interventions: (a) the fragility of the group constitution, with the slow establishment of the group boundaries with the importance of the formative work at this stage; and (2) the disruptive mechanisms that, simultaneously, block the constitution of the group, and act favoring the resistance of each member to maintain his/her symptoms.

We will describe some of the content of each of the first ten sessions, discussing the selected material from the perspective of analytical group psychotherapy and psychoanalysis of link configurations. We will try to shed light on the main processes and mechanisms of group interactions, and of the emergence of individual and interpersonal conflicts. It is important to stress that the group

sessions are rich in contents, expression and processes, and it is impossible to portray this totality with justice, thus we are obliged to carefully selection the material. We will attempt to characterize the constitutive elements of each session that allow articulation between the psychosomatic symptoms, their translation and a possible elaboration within the group.

Our fundamental objective is to analyze the initial steps of a group of psychosomatic patients, characterizing the ways in which these patients become a group and discussing how group psychotherapy can help patients to understand the nature of their symptomatic manifestations as psychosomatic symptoms.

The sample

The participants are men and women presenting with psychosomatic symptoms, from low to middle socioeconomic classes. All of them were clinically evaluated and accompanied by doctors of different specialties for the diagnoses and treatment of their organic diseases. Often the main disease presented did not match the label of a "psychosomatic illness", but the criteria adopted for the selection of this group was the presence of some psychosomatic complaint.

After being referred by their doctors for a consultation in the psychosomatic sector, each patient was evaluated by psychodynamic interviews and a careful examination of their records. At least two interviews were undertaken for each patient in order to identify their problem and to decide the adequacy of group psychotherapy. The exclusion criterion, as is sustained by the majority of group analysts, is the presence of a psychopathy. Patients with psychopathic traits were referred for another type of treatment.

The group was formed by patients complying with the aforementioned selection criteria including some patients from a previously existing psychotherapeutic group.

Procedure

The Psychosomatics Sector, part of the Psychiatry and Medical Psychology Department of FAMERP (Medical School in São José do Rio Preto, Brazil), receives patients referred by professionals of different medical specialties. Treatment takes place in a room, with chairs forming a circle, and two doors, one for the entrance of patients and the other for the therapist and the two observers (two trainee psychologists).

Therapy consists of weekly one-hour sessions with a minimum of two patients. Three unjustified absences of a participant were permitted. The group structure was open, that is, new participants could be added at any session, depending on the group dynamics and group evolution at that time and the specific problem of the new patient. The problems that this organization caused will be discussed later.

This group setting allows, as this is a public service, a large number of patients to have an opportunity of specialized attention. The group is continuously warned about the possibility of the inclusion of new members. The ideal maximum number is eight patients for each therapeutic group.

The work of conducting the sessions and interpretation is accomplished by the therapist. The role of the trainee psychologists is to observe the group (non-verbal communication, interactions, situations, climate and group speeches, the effects of the therapist's interventions, etc.), with no direct interference in the group dynamics. After each session, therapist and observers meet in order to discuss the content of the session and any observations. In these discussions, the aim is to deepen the comprehension of the group processes and to plan future interventions.

Each patient is oriented to keep strict confidentiality about the contents of the group sessions, albeit that in public services, with patients staying for a short period of time, many interactions occur outside the setting, for instance, in the corridors, the queues, in the patients neighborhood, and so forth. This issue is explored and interpreted in the course of the therapeutic work. For the purpose of this paper, the names are fictional and all biographical data have been modified in order to protect anonymity.

The group setting for psychosomatic patients is not different from that of other patients. We understand that psychosomatic patients show similar psychical conditions as neurotic patients, except for the singularity of their symptomatic manifestation. Their "stage" is the body and its functions; it is in the embodied symptom that we investigate the core meaning by therapeutic work. The elaborative and interpretative work is the same: the symptoms must be connected to their unconscious determinants.

Description of the Process

Session 1

Four members of the psychotherapeutic group are attending, with the fictitious names: Nancy (43 years old), Serge (38), Louise (40) and Rose (71). The therapist in charge is Lazslo (47 years old), and two observers: Andrea (28) and Renata (25).

The group begins with Nancy telling about the termination of a previous therapeutic group which she belonged to and which she left before the end of the process. Describing her history to the other participants, this patient points out the developing sensation that this may be the resurrection of her former group. After the speech, the psychotherapist introduces himself and the two observers, and stimulates other members to speak.

Serge says that he has no problem; his only complaint is his high blood pressure. He does not understand why he

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is participating in this group. Louise describes her stomach ache, that she can not swallow, the food sticks in her throat, *"like a ball"* (sic). Nancy introduces herself and tells that her problem is lack of energy, besides her difficulties in her relationship with her sons and daughters.

In this initial presentation, group members identify themselves mainly via their somatic symptoms. Although they are in a hospital, where the cultural reason for being here is obvious, in a deeper sense, the somatic symptom is a label in the identity of these individuals, their identification badge, the signal through which the first identifications between the members of the group can appear and, of course, the selection mechanism for inclusion in this group.

When Serge says that he is not similar to the other participants, because he "*has nothing*" and his symptom is merely physical, he shows his resistance to his symbolic entrance in the group. At the same time, he wants self-assurance about a particular relationship with his experiences, where he and his symptom form a closed system. His body "speaks", but he does not acknowledge this language as expressive of his identity.

Rose enters in the room, late, and the group interaction suddenly changes. In an idiosyncratic way, when she introduces herself she makes an immediate link between her somatic problems and her psychical life. She says: "*Look at the skin of a neurotic person!*", and just after that: "*I do not know why I have such thick skin"*. This patient suffers from psoriasis and she was receiving individual psychotherapy by the same therapist of this group. Rose is responsible for her symptom, and is different to Serge, who feels apart, as if he had contracted his problem, from the outside world.

Louise starts to talk about her husband, saying that he is a very demanding person, who does not accept her brother's visits to her home. Nevertheless, she says that she made a correct choice in marrying him, and she has to accept her husband's behavior. Nancy describes her ex-husband as a very difficult person and says that this was the reason for the end of her marriage. Serge remains still but, at this moment, interferes: "*If this happened to me, I would die*", and soon after, he completes: "*If this happened to me, I would kill myself*". The group does not show any reaction to his intervention.

Louise and Nancy discuss painful family questions telling about their families. They share the pains, and apparently have very conflicting relationships with their husbands and predominantly symbiotic links with their sons. Their descriptions allow them to recognize each other, giving mutual support. Serge looks to the wall and, when questioned, says that he is reading a small note about the physiology of the circulatory system. He says that he feels the same as is described in the note: "*a thing*, *a sensation*, *a small manifestation*". Serge makes, at this moment, a connection between his symptoms and the content of the session. But he uses an element external to the group dynamics, as if he departed from the affective movements of the group. The "*thing"* is indescribable, a psychical element that emerges, but which can not be acknowledged as psychical, and is attributed to a body disorder. The feelings are not linked to the symptom, Serge wants a physician and not a psychologist; he wants to suffer from the body, not from the soul.

Session 2

Three participants of the group are present: Susan (recently included, 38 years old), Louise and Serge, the therapist (Lazslo) and the two observers (Andrea and Renata). Nancy and Rose are absent.

Susan introduces herself and says that she was invited by her aunt (Rose – patient of this group) with the agreement of the therapist to take part in this psychotherapy. She monopolizes the speech and says that she has a very difficult relationship with her husband, her sons and her brother. With the latter, she affirms that he "*wants something else*" from her, suggesting incestuous attitudes. Susan describes her depression and says that her state changes and sometimes gets worse, and that her "*cry"* has been blocked in her throat for a long time. She interrupts her story, and asks Louise why she is attending the group. Her discourse is intense, confused and disjointed.

Louise answers, looking at Susan and the others, saying that she is attending the group due to a problem in her stomach and that she feels is different to Susan because she cries a lot for no reason. Susan shows interest in Louise, but soon after looks at Serge, and begins a dialog: "*And you*?"

Serge looks at Susan and says that he also does not cry, and his unique problem is his blood pressure. Susan answers Serge saying that maybe "*you cry with your heart; you may have no tears, but you cry*" (sic). Serge says that he never cries, even when he had a boat accident, not even when his father died. Susan questions him, asking about the accident, but he did not tell to the group immediately. She insists sharply with him, almost like extracting his history from him. Serge, showing apparent tranquility, tells about an accident involving him and some friends in a lake. The boat sunk and he had to float a whole night to survive. Susan asks him if he was afraid. He answers that he was not, that he "*just floated, that is it*". Susan asks if the reason for him attending the therapeutic group is this accident. This question seems to promote anguish in the group. Serge denies, saying that he is in the group just because of his blood pressure. Susan asks: "*Psychological pressure, maybe?*" Serge says that his blood pressure goes high, frequently. Louise asks him if his blood pressure changed after the accident. Serge says that there is not a direct relationship, although his blood pressure de-compensated just after his father's death, which occurred a few months after the accident.

With this description, we can hypothesize that Serge felt anxiety of death and of dying, but he acts and express

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himself as if he was not aware of these feelings. The somatic symptom of blood pressure variations takes the place of the trauma, conforming to a body symptom (McDougall, 1991). There is also a similitude in the psychosomatic functioning of this patient and the process that Pierre Marty (1994) calls dementalisation associated with somatization, due to deficits in the construction of pre-conscious representations.

The session was marked by an emotional climate, with intense interactions. Susan shows strong hysterical traits and is able to mobilize the group. The observers describe that they felt confused about the 'actuality' of the facts Susan told, but they felt concerned and moved by her narrative. Susan also provoked questioning of the observers, who fantasized about being 'invaded' and pressurized to speak, loosing their roles of passive observers. The history of Serge also mobilized the therapeutic team.

Session 3

Five group members attended: Susan, Louise, Serge, Rose and Nancy with the therapist (Lazslo) and the two observers (Andrea and Renata).

This session started with the presence of only Louise and Serge. Soon after, Nancy arrives, and then Susan and Rose arrive together. So, there are three beginnings, three entrances that provoke physical changes and changes in the relationships, altering the group dynamics. Louise and Serge say that they continue with their symptoms, Louise with her stomach ache and Serge with his blood pressure oscillations. Nancy enters, saying that she is "*a bit better*". The interaction climate is cool; they seem like friends chatting, without any anxieties or conflicts. Susan and Rose enter in the room and apologize for the delay. Susan says to Serge that he seems to be "*clogged up*". He answers that he is only listening and seems to be annoyed. At this moment, Louise stares at the other members, her eyes showing threat.

Nancy smiles when Susan questions Serge, and says that Susan did not change, and that she missed her (both patients took part in the previous therapeutic group, Nancy is referring to the character, provocative and inquisitive, of many interventions coming from Susan). Susan looks to the therapist, then to the group and says that Lazslo does not say a word, but when he speaks, the group should pay attention and remember what he says. Susan then starts asking personal questions to Lazslo, such as which are the colors of his private office walls. Lazslo asks her what colors she imagines, and why is she interested in this subject. Susan answers that she imagines a dark office, and adds that she would like to destroy it. She looks at the group and says: "*I would like to be a scorpion, so I could sting myself… or Lazslo*".

At this moment, Rose interferes and says that Susan is talking "*bullshit*" and that she disturbs everybody and should "*be arrested*". Rose acts as a censor, repressing excesses, especially sexual ones. It is important to stress that she is Susan's aunt, and functions as a kind of externalized 'super-ego' for her niece. Then, Rose shows her arm skin and says that the onset of her psoriasis was just after her father's death. She describes her youth, her duties with her brothers, and how her first episodes of psoriasis appeared as reactions to several life situations. With her account, Serge, who was until that moment, with his head bowed, apparently alienated, looks at her, seeming to identify with Rose. The repercussion of death is present, as if the description was about the possibility of his death.

So, sexuality and death dominate the fantasies of this session, the predominant climate is depressive. The group links are becoming strong, with continence for the psychosomatic manifestation as well as for the singularities of each patient.

Session 4

Five patients are attending: Mary (54 years old) and Joan (37), both recently included in the group, Louise, Serge and Nancy with the therapist in charge (Lazslo) and the two observers (Andrea and Renata). Rose and Susan are absent.

The therapist starts the session asking to the new participants to introduce themselves. Joan initiates telling her life story and shows deep emotion when she describes how her father abandoned the family. Her speech dominates much of this session, mobilizing the other patients, who turn their attention to her.

Lazslo asks for the opinion of Serge and Louise, in an attempt to stimulate group relationships. Nancy stays still, paying attention, and sometimes asking Joan questions and advising her. Louise and Serge seem to be moved and discuss how to react against such a father, if Joan should or should not look for him, how she could manage to do that, and so on. Lazslo interferes at that moment in order to permit the participation of Mary. With a very low pitch, her voice controlled, Mary starts saying that she has lupus on her face. Her disease started just after an argument she had with her mother. She tells that the beginning of her troubles was when she asked to borrow some money from her mother, to buy a car; promising to pay back the money quickly. Her sister heard about this and accused Mary of exploiting their mother. Mary wanted to prove her innocence and returned the money. Showing deep conflict, the patient describes that her mother supported her sister, causing her much "nervousness". Just after that, the stains appeared on her face.

Louise demonstrates comprehension of Mary, comforts her, and shows she identifies with her reactions to the suffering. Nancy and Joan also pay attention to the story, while Serge stays silent, with his head bowed. When asked, he answers that he is paying attention. Louise says that Susan did not come to provoke him, looking at him. Serge smiles.

This is a very typical posture of Serge, who seems to be alienated from the situation. When pressurized, he may react, saying: "*This is something that exists only in your head*". The interactions become poorer and the group

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perceives that it is a complementary role of Susan that makes Serge to participate. This latter patient seems to personify, at this moment, the group resistance to the clarification of their symptoms. His stereotype seems to protect him from facing the unknown. Based on Pichon-Rivière (1998), we could say that the amount of his persecutory anxieties block his progress in integration. The absences also show this defensive character, resulting in significant changes in the group dynamics. In this session, due to the new participants, there is a great redefinition of places and roles, therefore, changing the link patterns and the themes discussed by the group.

Session 5

Four patients are present: Susan, Serge, Rose and Nancy with the therapist (Lazslo) and the two observers (Andrea and Renata). Joan, Mary and Louise are absent.

The therapist starts the session asking how they feel. Rose says that she does not know what to do, that she is old, she does not have a husband, her spouse died, and that she needs to move from her house. Her speech is fast and repetitive. She is ambivalent, sometimes busy and hopeful, sometimes helpless. Nancy makes an attempt to help asking her about what her preferences are. Rose answers she likes to take care of babies. Then, Nancy says that people like Rose, and she can do things, such as taking care of children, helping people, and suggests to her to look for a children-care institution. Nancy (who is sitting next to the therapist) pays attention to the group discourse, gives some advice, discusses the conflicts of others, but never tells about her own difficulties, does not bring her subjective issues to the group screening.

Susan completes what Nancy was saying and tells the group that Nancy can take good care of babies, since she once took care of Susan's babies. Rose agrees that she likes this task but remembers the last baby she had to look after. She tells that the infant was sick when he left the hospital, and when Rose gave him his first bath, he became "*purple*" and almost died. Rose, then, returned him to the mother, who rushed to the hospital. Rose says that her life has no solution, no way out, and that she can not even visit her siblings. She says that some of her brothers died, others live far from her, that she can not visit her sister as the sister's house is too closed, and she can not smoke there.

Susan (Rose's niece), tells the group that another of Rose's brothers is very sick. Rose says that she knew nothing about, shows sadness and expresses that she can not bear any more deaths, as she is unable to deal with this. She describes her desire to go to some place, full of flowers, but she does not know where this place is. It seems as if Rose was referring to the cemetery, as if death were the solution, although being unacceptable. She suffers in a very ambiguous way, expressing how her own death is an ever-recurrent theme, nevertheless never conveniently elaborated.

The observers comment, after the end of the session, that albeit Rose's speech is melancholic, this is not the feeling that she provokes, but a feeling of vitality. It is difficult to access the pattern of the counter-transference reactions that she incites, but it seems relevant that the observers think of her as a funny person, who conveys an idea of life and libido.

This session's dynamic expresses the variation of different link configurations. When Rose and Susan come along to the session, generally they dominate the content, both in the number of verbalizations, as in the themes worked through. The absence of the others removes their themes from the session.

Session 6

Five components are present: Louise, Serge, Rose, Nancy, and Mary, the therapist (Lazslo) and the two observers (Andrea and Renata). Susan and Joan are absent.

Rose initiates the session saying that Susan is not there. She says that maybe she has been sleeping for many days and this is the reason for not coming, probably due to "*lots of calming drugs*". Then, she extends her painful hands to the group, and says that she can not support dust. She laughs, and says that she does not like that her neighbor comes to her house to talk to her, "*everything annoys me*". She declares that she does not go visiting her sister because she has to smoke near to the window and Rose feels this is rejection. For her, the external world seems terrible. We think that Rose attacks her capacity to think, making changes in her attitudes and her perception of her relationships difficult. Her thoughts seem incapable of abstraction, leading to poor symbolization and meaning to her acts. However, she sometimes demonstrates therapeutic evolution when she performs a symbolic reading of her symptoms. ("*Look at the skin of a neurotic person*", she said in another session).

Louise supports Rose, saying that she also can not support any dust and that she feels necessity to clean thoroughly her home and her work place. Louise identifies, with horizontal transference (between group members) with Rose, maybe because both of them have similar structural elements. We think that both use a concrete form of thought, promoting excessive adhesion to the reality, without criticism of that same reality and from the aspects of their internal world that urge transformation. Their symptoms act as protection barriers against changes and their potentials become inhibited, with the projection of these conflicts of the external world, always responsible for their own suffering.

The group movement is towards an intention of changing Rose; Nancy, for instance, speaks to her: "*Pay attention, I can only change myself, I am not able to change others*". But she is an expression of the same difficulty. Mary says that she is a little better, although still suffering from the problems she carries. This patient revives her history, making continuous links between the shame she feels due to her

'marked' face, and the conflicts lived in the relationships with her mother and sister. The hypothesis (not yet verbalized by the therapist) is that Mary wears a mask, a false self, which is loosing its covers; her conflict in the face is revealing her. She feels ashamed of being accused by her sister, and seems to be unconsciously ashamed due to the rivalry and hostility she feels towards this sister. Her body symptoms seem to have certain function of secondary gains demonstrating that she is the one who suffers, she needs support, help, and so forth. We work with the implicit idea that the psychosomatic symptom is a message, translating something very important in the subject's history. It is in this sense that the patient is stimulated to search for the links between her symptoms and her biography, even when this does not allow an immediate insight.

At this moment, Nancy interferes and says that it is very difficult to understand what Nancy says: "*My God, you speak inwards… I shout, I speak outwards!*" Contradictorily to this, Nancy does not assume the role of a patient, acting as if she were a monitor, fixed in a function of a kind of therapeutic agent for the group. She looks at the pains of others, directed towards the others and never towards herself as part of the group and subject of her own pains. Nancy defends herself from the psychical pain and from the possibility of achieving elaboration of her conflicts, using the others as a projection screen for her obscure unconscious aspects. However, this was not interpreted and she left the therapeutic group, together with Joan. This was her last participation.

Serge, always with his head bowed, when questioned answers that he does not pay attention to the discussions because he does not feel well, and he considers that this is due to his blood pressure oscillations. This patient metaphorises, without being aware, the pressure the group feels, derived from the arising conflicts. So, he functions like radar for the group. But, as he does not have the condition to represent the content of what he feels, he can only translate his sensations into psychosomatic symptoms. This vacuity of mental representations makes the elaboration process difficult, without the support of the patient's speech. It is his body, in full concreteness, that is in charge of enunciating the questions that disturb his psychical life. For the group the task is to find the necessary translations of these symptoms in the body into emotional meaning. Psychoanalysts, working with somatizing patients, point out that «typical operatory patients» do not develop actual transference neuroses. They only seem capable of transferencial reactions that some authors call *behavior neuroses*, making clinical care disinteresting and dry (Rocha, 1988). Nevertheless, the group, with its dynamics, can offer the possibility of rescuing the meaning.

Session 7

Only three patients are present: Louise, Serge and Mary, as well as the therapist (Lazslo) and the two observers (Andrea and Renata). Susan, Rose, Nancy and Joan are absent.

The session starts with Mary, who is eager to talk. She tells that she felt sick; she had a meeting with her mother and was not able to re-establish the relationship. She says that after an argument, her mother rejected her, saying her sister was correct in their argument. She resents her mother's attitude. Louise, in an attempt to help her, says that a good idea is to go to the church at these moments and pray. In the church she would find many people who could support her. Lazslo asks Serge what his opinion about this is. Serge answers that Mary's conflict is something "*born in her head*" – this rejection of her mother that she feels probably does not exist. Lazslo says that when we project aspects of ourselves, we reflect in others what belongs to our inner life. Just after the intervention of the therapist, Louise stresses the importance of God. She says that He can solve all problems if you have the faith and pray; religion is an important shield against anguish. The attempt to null the therapist is evident, making him impotent in the face of the group, only God can help them. We can hypothesize an ambivalent expression of the transferencial relationship with the therapist, confounded or equated to God. It is also a general projection, with God representing the totalisation of the meanings. Thus, pain, cure, symptom, everything find an ultimate explanation. The subject is eclipsed, and is not obliged to anything, as it is God's job to cure. It seems there are, in the group, attempts to deny any hostile drives against the therapist, with consequent idealization. Although such an idealization has a defensive function, it permits the group the possibility to stay, to keep in touch in a kind of relationship where they took part in a group project. When this interpretation is given, the group reacts with a new movement.

Mary says that she has a boss who has always taken care of her till the present. "*Madame Helene is just like a mother to me*". With this, she shows her quest for a substitute mother, abandoning her own mother whilst complaining of being abandoned by her. She seems to demonstrate feelings of guilt, talking more than the other participants, and suggesting greater authenticity and deepness of questioning. Louise offers her telephone number to Mary, and simultaneously says that sometimes she does not answer to the phone because she is not at home. Perhaps she is expressing the ambivalence in the desire to link with another participant of the group.

Session 8

Only two members of the group: Louise and Rose, besides the therapist (Lazslo) and the observers (Andrea and Renata). Susan, Serge, Nancy and Joan did not appear.

The therapist and observers are very anxious because they have to tell the group about the sudden death of a member, Mary. The news about this was totally unexpected, since she did not show any signal of sickness, even in her last participation in the group. Mary was a victim of sudden meningitis, last weekend.

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Rose starts telling the group about the death of her brother, asking: "*When am I supposed to stop losing people"* (sic). Louise asks the therapist why the other members are absent. She says that they should come for the session to take place. Immediately, she refers specifically to Mary, questioning about her presence. Lazslo tells the group about her sudden death, due to meningitis and from her disease (*Lupus erythematosus*, a kind of auto immune disease). At this moment, Louise seems incapable of understanding, shows difficulties to hear, and Rose declares that she did not know Mary. Louise is sensitive about Mary's death and remembers that this person would telephone her. They ask, once more, about the other members, and demonstrate a relationship between links and losses – as it is so difficult to establish a meaningful contact with others, if there is always a threat of loosing, abandonment and death.

Louise relates that a poor man entered in her bar and tried to rob her, but she fought with him with a stick and was able to recover her belongings. Her description has a hypo-maniac accent, with strength and vitality.

The theme of all the session is centered on issues such as death and robbery. The therapist interpreted this association as pointing to an unconscious production where death is a thief that kidnaps what no one wants to give up. How is it possible to escape from this thief? The group, as a whole, is also subject to dissolution, to the loss of members, to the death of their projects of elaboration. Louise is a special link in the clustering of the group, she is an aspect of the desire of this group for health and continuity. She seems to translate her understanding of this place when describing her action against the robber.

Session 9

There are three members: Louise, Rose and Susan; the therapist (Lazslo) and the observers (Andrea and Renata). Nancy, Serge and Joan are absent.

The session starts in silence. After some moments, Susan tells about the lack of production of the group, that no one expresses themselves, nor initiates any theme. She says that Lazslo also does not speak, that she wants to put him on her lap and spank him. She asks about his house, clearly showing a game of seduction.

Rose intervenes and says that Susan must stop asking "*bullshit*" (sic). She continues saying that it is true that Lazslo does not speak in the session, but "*on the TV, he speaks… I even put my chair next to the television set to pay attention, to try to understand, to learn with him*" (sic). She continues discussing about death. She says she would like everybody to die, as if the best way to deal with death is never to connect with it. This lack of links becomes the emerging theme of the group. The interaction becomes superficial, the issues of the members are not completed and it seems as if they can not hear, avoiding to deepen their links. The group proceeds, thus, its attempt to elaborate the actual death of Mary, and the symbolic death of each person's and the group's therapeutic project.

Rose says that she likes the color white and, if she could, her home would be like a hospital, so much she likes cleanness. At this moment, the group seems to be asking: should we be contaminated or should we isolate ourselves? The therapist speaks about white, about filth, the necessity of cleaning, to be freed of all dirt, and about the meaning of all that. He says that frequently people confound contact with contamination. Rose seems not to hear nor understand what Lazslo says, showing rigidity in her thoughts. Those reactions are interpreted as an attempt of the members to protect themselves by isolation from pain, rage and the anguish of loss. The latent theme is, with no doubt, the death of Mary (black against white) and the different ways to deal, consciously and unconsciously, with this matter.

Susan, in her habitual way of interrupting the direction of the interactions, promoting free associations, tells that she has slept for three days. She says: "*It seems that I am 18 years old, but I am 38* (sic)". This content was not interpreted, but it suggests her use of isolation, her sleep, is a defensive process. Appearing as if she wants to re-start the seduction present in the beginning of the session, she play acts Sleeping Beauty, immune to death and solitude. Ambivalent, she presents the hysterical symptomatology, seductive and simultaneously showing her difficulties to be in contact with her sexual fantasies, because her sleep keeps her husband away (and devaluated). In the group and with the group she sleeps as well. In Greek mythology sleep is depicted as the benign brother of death.

Session 10

Again, three members of the therapeutic group: Louise, Susan and Rose, the therapist (Lazslo) and one observer (Renata). Nancy, Serge and Joan, as well as the trainee Andrea are absent.

This session is marked by the dual relations established from the beginning of the session by the pairs: Susan / Louise and Susan / Rose. Louise tells that she is nervous: "*I was in my bar, and I climbed on to a seat. One man provoked me saying that I climbed well. I answered that it was his mother who did that* (sic)". Then, Louise tells about her stomach ache and that this night she had to put a pillow over her belly due to the pain. Susan immediately asks her: "*What are you really lacking, for you to sleep with a pillow?* (sic)". Louise does not answer her, Susan seems to be inviting her to share her experiences and/or confessions, and says: "*Louise, in our lives, we like several men* (sic)". After a short and tense silence, the three members start discussing about eating excessively and getting fat. Lazslo asks them if they would like to get pregnant. They talk about maternity and children.

Louise says that children do not ask to be born therefore they must be well cared for. Susan becomes exalted and

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enraged with this phrase from Louise, and answers that a child is responsible by his/her own life, knowing what is wrong and what is right. Rose does not take part in this discussion, while Louise and Susan sustain different viewpoints, she relates that she would like to have been a mother, bringing a fragment of personal life, denser of meaning. Some identificatory interactions occur within the group.

At the end of the session, Susan directs her speech to Renata, the observer, telling her that she perceives that Renata likes the group very much. Susan invites the group to talk with Renata. Louise says that Renata seems to be only 18 years-old and grabs her hand. This age, exactly, was mentioned by Susan, last session, to describe herself. Maybe protected by the relative isolation of Renata; since Andrea is absent, they seem to bring their projections over Renata. Possibly they make the projection of the figure of the daughter (maternal transference, made possible by the supposed relationship between the father-therapist and the daughters-observers). At the same time, we understand that acting out happening (groupal acting out), where the explicit interaction between participants can reproduce the projections occurring over the observers.

Discussion

A set of important questions arise in every group attendance. Among them, we can list: What is the phenomenon called groupalization? Which are the psychical changes seen in individuals and in the group as a whole? What is the therapist's interventional strategy and what are its effects? How does the unconscious affect group interactions? Based on the present description, we aim to focus on the following questions: (1) Are the therapeutic group an efficient means to produce changes in psychosomatic patients? (2) Does the proposed setting, an «open» group, contribute to, or hinder, therapeutic efficacy? (3) How does the institutional setting manifest itself (expresses/interferes/ allows or blocks contents) in group characteristics and in the interventions? (4) How does the process of symptomatic production influence the organization of themes and the group culture?

We will initiate this discussion with the last questions, leaving the first for the final considerations because of their great relevance to our proposition. Open groups are almost a requirement in institutional work. The high demand of patients waiting for consultations and the continuous referrals in public health services, make the proposal of permanently open groups the most appropriate format, both in technical and ethical terms, in this reality. Technical, because patients commonly abandon group therapy, as has been acknowledged in the literature. Thus, the group structure becomes fragile by the continuous loss of members, with new participants expanding the possibilities of the consolidation of the therapeutic project. On other hand, the ethical question constitutes the primordial issue in any therapeutic action, and there is no justification of depriving patients of attention only for the sake of maintaining the rigidity of a technical rule; the technique must serve the necessities and not vice versa. In the field of subjectivity, by definition, ethics is involved.

Nevertheless, it is necessary to acknowledge that a group with an open structure brings to the forefront a large number of difficult questions. This feature may contribute to difficulties in generating a protective and supportive space; hence, it may increase the participant's resistance. The inclusion of new members causes notable changes in group dynamics. The new participant, merely by his/her presence, profoundly modifies the existing network of roles –altering the configuration of identifications, producing new affective links, struggles for group positions emerge, alliances are reconstituted, subgroups emerge and disappear, and other attitudes in respect to the therapist and the group objectives are established. Thus, new participants imply the creation of a «new group», different in each new session.

Otherwise, and for the same reasons, the continuous entrance permits the renewal of group productions. This gives birth to the new. Resistances to the changes arise, but they can be continuously worked through. New roles, new characters, new scripts, everything is disturbed and shaken up by the changes in the interactions. The symptoms are confronted, articulated into new configurations, they fight and suffer, and new analytical angles are gained.

We perceive, in this group, that new elements entering in the group, or the confirmation that someone would never return, brought a return to the physical complaints, the somatizations come back. The first session was marked by characterization of a description of the physical sufferings of each member, which seems to mimic a first movement of defense against the meanings and the feelings (and also, to the possible links brought by the presence of the «others» of the group). The importance of the environment must also be stressed, because to be in a hospital leads to an evident question of a fundamental aspect of transference, the institutional transference (Lapassade, 1977), affecting the patients, the therapist and even the observers.

The institution where a therapeutic intervention takes place affects the process in many ways, both intra-psychical and inter-individual, since the institution is omni-present in the ideology, in the hours, in the rules, in the prohibitions, etc.. In the present situation, the hospital affected the setting (restriction in the schedule of the sessions, the gratuity of the service), as well as the selection of personnel. The out-patients department is organized to attend a standard demand, organized by medical parameters and it restricts the freedom to establish rules specific to a therapeutic group. However, it is also a task of the group to analyze this factor that determines its existence, and thus, the rules that make its institutional existence possible should also be the object of analysis.

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Let us move on to another point, focusing on the importance of intervention in therapeutic groups for this population. This group lived the drama of the death of a patient, due exactly to her pathology. As we have already mentioned, each patient of this group was previously examined by doctors, who made the diagnosis and treated the organic diseases of patients. When patients are referred to the psychosomatics out-patients department, they do not interrupt their organic treatment. Even so, the death of this patient brings ethical and technical issues. In our opinion, it is indispensable that psychosomatic patients have their symptoms attentively considered, and never regarded as minimal, or imaginary. Every human suffering, especially diseases, has some psychical dimension, but this is not sufficient to conclude that psychotherapy is enough to totally care for psychosomatic patients. In our work, there is continuous discussion with the medical clinician, and the treatment must be coordinated. The death of this patient was sudden, due to characteristic progress of her disease (*Lupus erythematosus*) and the fact that death occurred during psychotherapy only adds a human and interaction dimension to the condition of her illness.

Therapeutic groups with psychosomatic patients imply in technical issues, too. We start with the general meaning of the groupality in psychical life. According to Fernandes (1996), forming links is essential both for our intra-psychical survival and for the construction of social relationships. In the group approach, there is a path from the individual to the collective, providing a binocular or two-way view of existing transit between each participant and the larger context of institutions and society.

In any human relationship there is permanent projective and introjective interplay. In the therapeutic relationship, those successive projections have, as their main consequence, the production of intra-psychical changes in the field of inter-subjectivity. In the group, the therapist is the receiver (the continent and the common and permanent transferencial object) to whom all the free associations dynamically connect, converge. Here lies the transferencial basis through which the interpretations pass. Having Bion as a reference, the group is perceived as a totality, integrating all the free associations of the participants, as well as the counter-transferencial aspects of the therapist. Such comprehension permits the interpretative work by means of the understanding and elucidation of the unconscious fantasy of the group. By the group process, each individual receives back the content, and in his/her inner group, promotes changes in the subject, and immediately, transforms his/her interactions in the links that cross the group.

The process of grouping represents an essential dimension of the process of humanization. Human beings can only live inside their links. Even to be born is essentially a relational fact. The psychism, as Freud clearly pointed out in 1921, in his masterpiece «Group Psychology and Ego Analysis» (*crowd* is the term originally used by Freud), is inherently constructed by the relationships of the subjects with their significant others. We are built by our relationships, and the group represents are the most concrete form where we can make operational analysis of the links that bind each individual to the group totality (Ávila, 1995).

We consider this approach important when dealing with psychosomatic patients. The participants of this group were able to create better conditions of mental elaboration for their conflicts and a deeper mind-body integration as is evident in several moments of these ten sessions. We understand that the evolution of the psychosomatic patient in the group is possible due to the condition of living all this interactional process in the inter-psychical field. The individual symptom finds an echo, expression, translation and meaning in the confrontation of the singular problems of the patients. The interpretation is simultaneous for the group and for the individual; because it has meaning for each one, and is shared with the others, it may provide a condition for each one to see themselves in the others and to see the others.

We believe that a patient like Serge would have great difficulties in an individual psychotherapy, making the investigational process harder, due to his close identification with his body symptoms.

The group mediates the comprehension of the unconscious meaning of the symptoms, creating a net for the circulation of contents that allows the patient to reach mental representations. These were not previously possible because the patient was unable to form them, maybe due to his «somatic complacence» (Freud, 1905), having converted them to symptoms of psychosomatic expression. From this appropriation that each patient can achieve in the group, insights are favored, both for the individual and for the group, and new instinctual destinies can appear. With mental representations, the symptoms do not need to be presented (Ávila, 2002) and their enigmatic character, like hieroglyphs, can now find the condition of language and once in the verbal representation field, they can achieve elaboration.

According to Zimerman (1995) relationships with other people, with the inevitable emotions of love and/or hate, always imply in risk of suffering that may be difficult to bear. In the same manner as when someone achieves knowledge of a certain internal or external truth, the acknowledgement of being dependent upon others provokes painful emotions. If an individual or group does not feel capable to face these emotions, generally unconscious resources are used with two objectives: the first is to avoid the problem; the second is to attack the perception and correlation of the respective links that would lead to psychical pain. We think that these factors may have participated in the abandonment of some participants of this therapeutic group. For Pichon-Rivière (1998) paranoid and depressive anxieties follow every development in the process of overwhelming resistance to change, and this evidently includes the changes in the psychical dynamics and its symptomatic manifestations.

Thus, we support the significance of the group for the resolution of psychosomatic symptoms. There are many important characteristics in the mental functioning of these patients. The inhibition of the unconscious fantasies implies in a severe incapacity that blocks the mental growth and the attainment of somato-psychical integration. Joyce MacDougall (1991) describes as primordial to the psychosomatic functioning an incapacity to represent unconscious conflicts, derived from the history of the development of the psychosomatic matrix that organizes the mind since the beginning of the corporal schema. But, on confronting the immense creativity of the instincts, there is a continuous effort of the mind to reach representation of the drives that are kept in a state of namelessness and absence of representation. Based on the original propositions of Georg Groddeck (1984, 1992), we search meaning for the «deaf» psychosomatic symptom. We propose groups as a concrete alternative for psychotherapeutic intervention, because the free group discussion may provide shared mental representations, favoring the expression of individual conflictive dynamics, in a more efficient way than in the slow search of adequate representations in the dual situation of individual psychotherapy.

We agree with Bombana and Duarte (1996) that group participants do not speak exclusively of their somatization, as members are interested in talking about different aspects of their lives. We observed that somatic complaints reappear generally when the individual was facing problems, returning to the 'scene' when the organ substituted speech, and the expression assumes a regressive character, communicating through and with the body. Several times we could perceive that the barriers to the groupalization were converted in aggravation of the symptoms and, inversely, the elaborative advances made gains possible both in the patterns of group interaction and in the level and intensity of somatizations.

Conclusion

What is the contribution of therapeutic groups in the treatment of psychosomatic patients? We believe that this group is an adequate case study for this question. In the ten sessions, we can follow the vicissitudes of forming a group with such a proposal. In the beginning, the group is only a "series» (Sartre, 1956, *apud* Lapassade, 1977), because the patients have as their unique common references that of being instituted by the same health institution, clustering them by their similar symptoms, and not by any personal project they might have. Soon, the group appropriates the image of the group, and looks at its history, first as the continuity of a pre-existing group (Session 1) and then as a group constituted by their interactions. Let us describe this history.

Seven patients participated in these ten sessions. One of them (Joan) came only in one session (the 4th) and another (Nancy) abandoned the group after Session 7. There is a clear oscillation in the participation; the dynamics reflects the presences and absences of individuals. The aunt-niece pair (Rose and Susan, respectively) provoked a specific set of interactions, marked by the hysterical symptomatology of the second patient, and on the other hand, by the complex unconscious links of their familiar structure. They were absent in Session 2, participated in Session 3, in Session 4 the pair Susan / Rose was absent, and in Session 5 it is this pair that dominates the group. In Session 6 Susan is absent again, and in the next she and Rose, and again in Session 8. In the last two sessions both of them participated. In the session where one or both did not come, new problems emerged, among them, the difficult situation caused by the death of Mary.

This patient occupied the center of group dynamics in Session 7. Her family problems were articulated with her symptom, which seemingly was the vehicle for her conflicts. In this case, a severe organic disease was manifested with close links to her personal biography, following and intensifying the emotional suffering, and at the same time, serving as an expression for them. Her unexpected death brought a severe trauma to the group, which was facing an actual death. The group reacted with structural changes in composition and a slow and painful process of awareness of the anguish and fears brought by the real and symbolic losses made present in the group situation.

These 10 sessions have this trait: the group has a fragile life. The dangers are enormous for its survival and permanence. With this, the objective was to produce a network strong and continent enough to protect individual differences, the violence of the drives that appear represented as psychosomatic symptoms, and the intra- and inter-psychical conflicts that are necessity to alter the pathological balance brought to the singularity of each patient in his/her own conflicts and in the face of the others. Was the group efficient in this task?

We think that this group was able to fight its fights and fears. Many previous symptoms were weakened and were substituted by speech and symbolic manifestations in group interactions. There were shocks, friction and arguments. There were fugues and ruptures. However the profound work of thought became stronger in each session. The psychosomatic symptoms of the participants were naked, and showed their psychical links, being articulated with the life histories of each person. The group proved to be an adequate stage for this work.

The efficient action of the therapist of the group is only possible departing from the courage of the group. Freud (1921) considered the group leader as an aggregative pole, from where the horizontal relationships of the crowd members were made possible. He said that the leader occupies the place of the ideal of the ego, common for all participants. That is the reason why idealization is the presupposition and a direct consequence of the group links. As Fernandes (1996) says: "The therapist is the receiver – continent and the common and permanent transferencial object – where all free dynamically related free associations

are connected. Here is the transferencial basis where the interpretation passes".

In this group, in these 10 sessions, as well as in many later sessions, we can say that therapeutic groups are a fully valid strategic alternative in the analysis of the meanings of psychosomatic symptoms. They are also a powerful device to help people who fight to become the authors of their own histories, and not of patients with meaningless symptoms. We agree that merely ten sessions are insufficient for such an optimistic conclusion, taking into account the wider reconnaissance in the specialized literature; they are difficult patients with various impediments to the resolution of their symptoms. However, what we presented allows the reader to follow the development of the group resources in order to "make thoughtful what is impossible to think", and create from a deaf and suffering body, the battle field for the construction of meanings that permit, as symbols, the humanization of the suffering.

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