Reflections on supervising groups of HIV positive patients with personality disorders

Silvia Corbella

Abstract
This paper is a critical reflection on the supervision of two groups of HIV positive patients with personality disorders for the duration of five years. The patients all suffered from personality disorders of various degrees, and they had became HIV infected through drug abuse or heterosexual or homosexual contact. The groups met twice a week for an hour and a quarter in the San Luigi Centre at the San Raffaele Hospital in Milan. They were open groups of men and women, counting eight participants in each group.

Key words: patients, personality disorders, group psychotherapy, homogeneous group

I believe the increase of personality disorders in our society, is not incidental. Social change has been rapid in western societies since the Second World War, creating confusion, and upsetting the importance of values. Existing social structures to compensate for possible failures in the family are reduced to a minimum. The lack of reliable models of identification in the family and social environment and the diffusion of models by the mass media, does not make the situation any better. The difficulties of our civilization today are in part caused by the widespread crisis of privileged values. Wilson (1980) describes the young in western societies today as "rebels without a cause". Thanks to reliable family environments and personal resources many have maintained a satisfactory development, while others, either because less gifted or because of childhood privations, suffer from personality disorders with unsolved problems of dependency, which only worsen with the use of alcohol and drugs. It is not my intention to propose an aetiology of patients with personality disorders in this paper. I only want to underline how today's society does not provide cohesive and reparative institutional structures to deal with serious family environmental deprivation, and to a certain extent even worsens the situation. I have observed that many studies demonstrate patients with personality disorders suffer from inadequate family relationships. This is not always necessarily the cause, but it is a risk factor. It is mainly believed that personality disorders originate in the very early stages of development where a lack or loss of an adequate holding causes difficulties during the process of separation-individuation. In this situation the lack of object-constancy determines the impossibility to have an integrated relationship so the object relations of persons with personality disorders are dominated by splitting, since the processes of differentiation were unable to follow a normal development.

All of this produces a fragile Self, a subsequent weakening of the ego's capacity to carry out its functions, and an anachronistic use of archaic defence mechanisms.
All the patients treated by me in both groups had personality disorders prior to becoming HIV positive, provoked by their particularly deprived family backgrounds. During the course of the therapy, listening to the stories they told of their life experiences, I always noticed certain characteristics they had in common, namely the lack of elementary rights often accompanied by a sense of guilt. It seemed as if these patients perceived a message from their backgrounds excluding them from the right to a valued life, leaving them at best the right to survival. These messages were not always explicit making them all the more dangerous. Furthermore, many of these patients were unwanted children with absent or narcissistic parental figures. Narcissistic parents consider their children as an extension of themselves, and are intolerant or disappointed with them if they don't live up to their expectations. So these patients never feel really wanted or appreciated for being their ordinary selves. They behave according to their parents' expectations, ending up by falsely gratifying them and/or else reacting with outright defiance. Some members of the group had parents with severe pathologies or specific addictions such as alcoholism or drugs; none of them had had "sufficiently good" family environments nor parental figures who were reliable or valid models.
When I refer to the patients' families I often use the term "background" because, in some cases a real and true family of reference was actually lacking and the existing parental figures were inadequate. These persons, even before becoming HIV positive saw themselves as "marked" persons and not in the mere social sense of the word but, as Zucca Alessandrelli (1995) writes: "The "mark" consists in the primary terror of not existing as a person, meaning not having significance and value as subject-object in a vital relationship.
Initially the child cannot reject the original family environment because of its absolute need to rely on it. It can be internalised in an attempt to control it, but as Speziale Bagliacca declares: "bad internalised objects nourish the super-ego that becomes hostile and causes a sense of guilt".
A patient of mine with a very castigating family environment said to me once: "it's the punishment that seeks out the guilt". The more the child is punished or ignored the more it feels guilty. Feeling guilty however, is not as annihilating as feeling impotent at the mercy of unreliable people. If at the beginning it's the punishment that seeks out the guilt, after a while it's the other way round; a vicious circle sets in that can be only interrupted by a therapy or paradoxically, the discovery of being HIV positive.
In most cases, the fear of dying sets in a deep and intolerable anxiety, and then after a while the need to question oneself on one's existence and to give it a meaning takes over. It seems as if the thought of imminent death, a final punishment inflicted on them, makes these people aware for the first time, that they have a right to exist, a right to a valued life and a right to be finally acknowledged and respected. In this second phase the proposal to start therapy is usually received favourably by a person

with the characteristics mentioned above. I believe group therapy to be the most suitable answer to these patients' needs. The small group with its particular structure that gives stability to the pluralistic physiognomy of daily life, seems to be the most advantageous instrument to comprehend the formation of identity (or pathological identity) in the building of its interpersonal elements. On this argument, Rouchy (1999) writes that the small group constitutes exactly the missing link in Freudian thought letting us see the transfer from the individual to the collective and vice versa, and comprehend not only the transition from one field to another but their reciprocal impregnation. Furthermore Foulkes reminds us that damage provoked by macro and micro-social situations is more easily repaired in a fit social situation like a therapeutic group for example.

To fully comprehend specific groupal dynamics, there are four elements present contemporaneously in the group space, possessing a complementary and parallel evolution:

1) the individual and his/her internal world;
2) the interactions between the members;
3) the transpersonal phenomena;
4) the group as a whole and all the phantasy representations it can assume;

The transpersonal phenomena can be observed in the synchronic or the diachronic sense. In the synchronic sense the transpersonal phenomena are linked to a modality of an archaic functioning of the ego, they are preverbal and presuppose the non separation between the Self and the objects; they appear in the "here and now" in the groupal situation either as a defence against the anxiety of fragmentation and separation, or as an evolving potentiality for the subject and for the group. Neri (1995) identifies them in the atmosphere, in the background tone that characterizes the different meetings, in the medium, and in the effects of the primitive mentality and the effects of the basic assumptions.

On the other hand, in the diachronic sense, the function of the transpersonal is a sort of "precipitate" that contributes to the formation of the Self. According to Rouchy (1998) the child has already incorporated the family culture when it is still unable to distinguish between physical and mental, forming a collective identity of the subject and the non-individualized Self. The incorporation of the culture is at the origin of relational space and time and conditions them. It functions unknown to the subject by automatism - in programmed channels, not "mentalized", and only thanks to the work in the group become visible and comprehended and therefore conscious, at this point they become integrated or if recognized as pathological rejected. Whereas to comprehend a group in all its forms, it is necessary to take into consideration the mother-child symbiotic orbit that is the rudimentary origin of the group which "is phantasized as being everything". This consents the group's specific dialectics of fusion and individuation to emerge, in which positive transformations come about for the single members and for the group as a whole. When I speak about dialects I don't want to so much as emphasize the confrontation of contrasting positions, but rather point up the distinctive functionality of the varied and complex aspects that emerge in

the phases characterized by fusional movement or by movement towards individuation. Once the therapist is aware of the exceptional value of the complementarity of the et-et paradigm and the aut-aut paradigm, it is his/her task to impede that one of these phases prevails over the other, maintaining a dynamic area that favours exchange between them, since both are essential for an evolutive development of the individual and the whole group. This dialectic movement traverses the groupal time and is created in the time of the group work. I find the metaphor of the spiral represents this concept of time rather well. It is like a spiral rotating around an axle that permits us to synthesize the plurality of dimensions and movements that make up a temporal experience in the group. One can go forwards with the possibility of returning to the same point in relation to the axis but at a different level, since multiple levels of reality are present contemporaneously in each session and for each individual.

In the fusion in the group, what takes place is the possibility of symbolically re-enacting the phase of the symbiosis with the primary object, which is fundamental for the development as it protects this phase from the grandiose Self and is the origin of the development of the true Self; but of equal importance is the possibility of sharing different and more advanced stages of fusion. Archaic stages of fusion are distinguishable from the more mature ones, as the last-mentioned maintain a sense of separability where merging can coexist with individuation. The ideal term for describing this experience is profound sharing.

The metaphor of the spiral also seems to be most indicated for describing how the groupal setting with its own particular modality differing from the individual analysis allows the possibility to move "freely" in time. Past, present and future can be potentially drawn on and interact in the "here and now" of every session. This moving "freely" is rarely experienced as a joyous fluctuating, but often coincides with confusion, anxiety, and loss of familiar boundaries, followed by moments of crisis, resistance and desire to escape. Hiv positive patients with personality disorders find the potentiality of the setting of the group of utmost importance for re-enacting very primitive levels of experience, that very level where their problems originated. Balint describes this fusional archaic phase as "the basic fault". This phase is distinguished by a lack of distinction between the subject and the object and a primitive fusional moment where phantasies of omnipotence emerge. The possibility of drawing on this very archaic level of existence is present from the start of the group's story because the boundaries of the ego become permeable in the group setting resulting in the common symbiotic zones coming into play. Regressing to the relationship with the primary object and therefore entering into the area of the "basic fault", allows the subject to repair the path of the grandiose Self (the base for the development of the true Self) and to experience, perhaps for the first time, reassuring moments of fusionality, an experience of "holding" within the group. During this course, thanks to timely interventions by the therapist and following moments of crisis and confusion, the group manages to accomplish moments of integration, experiencing the part-objects as whole objects.

Its not easy to illustrate the phases whereby a re-enactment of the archaic fusionality in which the synchronicity should characterize the mother-child relationship becomes the prototype of group interaction. This type of situation is experienced at a preverbal level where words do not possess their usual conventional adult significance but become a sort of transitional object. The exact contents of a session in which the positive aspect of this archaic level of regression has been experienced is difficult to describe, however, it is possible to speak of a prevailingly emotive atmosphere shared by all and characterized by mutual trust. Even the therapist is involved in this "peaceful fusion", which many patients with personality disorders have never experienced. At first when this phase is still on a superficial level the pronoun "us" is often heard; then "me too" becomes a sort of password. This "formal" fusionality that is present in a new group when the participants start to feel chaotically good together, gives origin to a more authentic and profound fusionality as the groupal process evolves.

When the regression to this kind of archaic fusion appears in the group it is important that the therapist does not interpret this situation as it would be seen as an intrusion, disturbing the intensity of the experience. Instead it should be allowed to evolve freely, as long as the therapist feels it has a therapeutic function. After a while the positive regenerating aspects start to fade and the therapeutic work becomes disturbed by certain anxious aspects. They are aspects of the fusional experience, linked to the fear of losing identity, along with anxiety for the fear of fragmentation regarding the emerging relationship with the part-objects; the therapist should reveal the danger of this state, offering the instruments to face it.

Coherence and a sense of mutual trust in the group improve, thanks to the fusional sharing experience and the capacity of the therapist to keep the risks at bay. The confidence that a "new beginning" (Balint) is possible, stimulates a more suitable modality of relationships with themselves and with others. The sharing of this experience also greatly reduces the fears of excessive dependence on the therapist, which often occurs in individual analysis. The therapist's behaviour doesn't interfere in the prevailing atmosphere in the group and, on the contrary, is calmly immersed thus helping to maintain this atmosphere, allowing members to understand that it is not the therapist, but the "group" which accepts that "sufficiently good" environment. It is an environment in which one can trustingly let oneself go in creative moments of fusionality and in which the group as a whole can function as an adequate substitute of the primary object. Generally speaking, patients with personality disorders find it particularly difficult to let themselves experience situations of archaic fusionality because such experiences, even if positive, are usually experienced for the first time in a satisfactory manner within the group. Since these experiences represent the unknown, they can provoke anxiety and/or defensive reactions of devaluation or flight. On the contrary, groups of patients with personality disorders, rendered particularly homogenous by being HIV positive, facilitate the emergence of a sense of sharing so that fear of the unknown, thus shared, provokes less anxiety and is more tolerable. Within these groups, interaction among the patients is striking because of

its characteristics of immediacy and demand for authenticity. These elements seem to stimulate remarkable acceleration towards much deeper levels of communication so that affective circularity, cohesion and awareness of the group as a therapeutic instrument occurs much earlier with these particular patients, rather than in other therapeutic groups. Having had the opportunity, in other situations, of supervising groups comprising patients in danger of dying (terminally-ill patients and those with serious heart diseases) has enabled me to understand that in many cases if, in the first phase, the fear of dying stimulates a deep and almost intolerable anxiety, which often places the group in A.B., causing dependence or fight-flight, but also union, later becomes readapted to its "natural" state, also because it is shared and therefore not denied. Room is opened up for tolerating the sense of uncertainty and precariousness in which, even if one does not feel healthy, or if one does not feel well, its possible to start "feeling well". The uncertainty and precariousness of existence in the world today should, in respect to this specificness, render the group of human beings "homogenous", but Western society in everyday reality has no time for these thoughts, striving to maintain its omnipotent narcissistic image. On the contrary, the idea that death is potentially a natural and thinkable event widens the horizon of life and stimulates one to ask oneself the sense of ones life and seek its deepest meaning. Lazzari, Campione and Chiodo (1993) believe that: "To free oneself from the tormenting and ever-present thought of an uncertain future full of painful surprises, some HIV positive patients dedicate themselves to new activities in their life, in sentimental, occupational, and recreational areas. One witnesses, in other words, a psychological "growth", a sort of "experiential 'illumination' where every aspect of oneself and of others takes on new significance, unexpected, but all the same true". Personally, I do not feel that a new investment on the part of those patients in danger of dying should only be interpreted as a way of freeing themselves from uncertainty, but also as a courageous and authentic way to assume ones real strength, however limited. The concrete reality of death, within a lay context personifies definitive impotence, but an "announced" death consents each patient to take back his life again with its positive potential. The group sustains and shares this new emotive position. In fact, as I stated earlier, group therapy for this type of patient represents the most suitable setting in which to face or rediscover (or even discover for the first time), awareness of oneself, and the value of life and life in general. The group, in fact, on becoming a work group, is considered by its members as an extension of oneself, as a place in which to exist, to speak, to look, to listen and to understand. Belonging to the group is continually nourished by the sharing of mutual experiences; initially anxiety and depression, by becoming means of communication, can be accepted and eventually modified. The experience of belonging, so essential for the construction or the reconstruction of the Self, enables group members to put into perspective and in part to solve their sense of inadequacy and guilt. As the work group develops, the individual stops accusing himself or others for his own defects and difficulties. In this way he starts to quit the dichotomous logic "aut-aut" , impotence-omnipotence, victim-hangman and to think in terms of the logic of "et-et", the logic of

complementarity, capable of accepting and giving meaning to the complexity of reality. The awareness acquired day-by-day, meeting after meeting, of their own potential and therefore of their real strength, can ultimately be founded on their acquired right to be, to be of value and on the duty to acknowledge that others have the same rights. The acquisition of these rights and responsibilities has been made possible by the group which, as Neri maintains (1995) often has the fundamental function of Self-object, that is the object which causes the individual Self to emerge, maintains it and gives it significance. At times it takes on the role of twin Self-object, which, thanks to the warm and affective presence of other people, makes an essential contribution to building the sensation of being " a human being among other human beings". This is of vital importance for these people, who so often feel "different". I would also like to emphasise, like Neri, that the experience of a relationship with a twin Self-object is stronger and more meaningful in group situations, than in individual therapy. In the group, in fact, just the fact of seeing each other and being many, makes the bodily presence of others much more concrete and explicit and stimulates the awareness of belonging to an active and functional gathering. All of this, however, in particular with HIV positive patients, should not be interpreted but, as in positive fusional phases, should be allowed to be experienced. One should bear in mind, as I stated earlier, that for this kind of patient a facilitating and welcoming atmosphere represents, even if positive, something "new" and unknown and as such is frightening and induces defensive reactions, including absence from group sessions. But this "acting out" which a patient may choose to adopt, has an important communication value for the entire group. In fact, on his return to the group, a patient who has "acted out" this fear also for the other members is welcomed into an environment, which, contrary to the past, neither despises or excludes him but gives him importance by helping him understand how he adopted the role of "someone afraid of the new" for everyone in the group. It is thus possible to highlight that fear of the new is a shared experience and thanks to "acting out" became communication that permitted awareness and elaboration. The patient in question and the group as a whole will be reinforced by this experience, thanks to the awareness shared by everyone that they can be understood, exist and act like other people.1

Returning to the fundamental function of the group as Self-object, I would like to bring to attention the possibility the group can take on the role as an ideal and omnipotent Self-object, as always happens during positive fusional phases. It is clear that patients must eventually pass from this phase, and not only once (spiral time), into the healthy phase of individuation. However, contrary to what has occurred in the past for most of these patients, it is essential that this passage be neither traumatic nor radical but gradual and shared so that the fusional experience remains in the history of the group as a reservoir of energy accessible in moments of fatigue and difficulty. As supervisor of different types of homogenous groups, not only because of the dramatic component of an "announced" death which I mentioned earlier, but also because of illness, age, mutual problems and interests, I noticed that a characteristic feature of the homogenous composition of the group is a natural

acceleration towards the sharing experience, while there is a definite resistance towards individuation movements, the necessity and value of which must, more often than not, be raised by the therapist himself. These groups, moreover, tend to offer, right from the early stages, a particularly joyful and participative reflection of the positive conquests made by the single members, providing a positive image capable of restoring hope and encouragement for new projects in an environment of profound affective participation. In a group aware that is functioning well, the success of each participant is considered as the result of mutual work, and becomes part of a shared history. In my opinion, the history of the group has a specific therapeutic function in the slow-open groups since it allows new members to share, at least through empathy, the conviction that they can face and solve their problems together. Another of its functions is to alleviate the tension produced during particularly dramatic moments by providing comforting accounts of conflicts, already present in the past and unresolved, analogous to those experienced in the "here and now" of the sessions with a consequent reduction of depressive anxiety. During the early years of work in particular, HIV positive patients' hopes of surviving had much more restricted temporal limits than now. This is why the story of the group took on a particularly important meaning since it also involved remembering the path taken by all those who had participated in a group and of keeping this memory alive. Awareness of this was of great comfort to these patients. Therefore if the historic-communitarian dimension in group work is a specific therapeutic factor, which promotes the development of both the individual and the group itself, in groups formed by patients in danger of dying, it has an indispensable function, that of guaranteeing "an inheritance of affection" in an environment of belonging where the right to the quality of life is recognised and shared and where the right to the quality of death is welcome; death seen as an inevitable event for all human beings and not the result of personal guilt.

The building-up of a mutual and shared history allows patients to achieve a positive synthesis between the synchronic and diachronic prospect, thus producing a reverse movement that is at the same time complementary to the movement towards individuation, laying down the foundations for overcoming fear of separation and solitude, since it binds the individual to others. When new patients join an HIV positive group or when new groups are formed, which sometimes include patients who have participated in groups that for various reasons no longer had a sufficient number of patients, there is always a patient who takes on the role of "aedo" of the group. This person becomes the spokesman of past history and revives the memory of people who are longer there and in a certain way puts the therapist to test to see if these patients are still present in his/her mind. Moreover, it is no coincidence that these groups celebrate more than others special events (such as Christmas and Carnival time), which seldom had been celebrated by patients' families. On these occasions photographs are taken and given to all the participants and, consequently, to the therapist and observer as well, in order that they keep them in, and for, the group.

Moreover, when the group achieves a shared history and is experienced also as a valid container of memories, it is no coincidence that group members' childhood memories emerge with even greater significance. Often patients with personality disorders commence their therapeutic work by maintaining they only have a few, vague memories of their childhood. They also tend to sketch this childhood in neutral emotive colours. During the course of group therapy it has been possible to discover that history and memories have a structural value, which also gives value to each of the individual components. Reassured by a positive sense of mutual belonging, patients can then distinguish themselves from the others, recovering their own personal history, which individuates them and to which they can finally give a meaning. Childhood experiences revisited from a safer standpoint are no longer annihilating and therefore no longer need to be seen from within a scenario where an omnipotent and persecutory sense of guilt dominates, a scenario where one either destroys or is destroyed. The group then becomes a place where old wounds can be seen and where patients can trustingly expect these wounds to be healed even if they are not always completely healable. The scars are the concrete results of our history, which enable us to face up to our limits and those of others. They make us aware that even though there are many objective conditioning factors and difficulties, there is always an area of freedom into which we can project our life. The knowledge that patients can be remembered prompts old memories and gives value to memory. This enables patients to feel constructively responsible for their own present and therefore project themselves towards the future. Once the need for fusional regression has been overcome, it is in this situation that patients will nevertheless return to different levels in the process of group development (spiral time). Sessions in which the group re-enacts the adolescent phase become more frequent and the group becomes a group of "peers" with specific characteristics. In particular, when the group re-enacts the adolescent phase, family role models are put into discussion and there is the possibility of building new values and providing new answers. At such times the therapist must know how to detach himself, while maintaining responsibility for the group. He/she must, therefore, know how to be present when necessary, even if he/she is no longer seen as the omnipotent and indispensable parent. Dependence on the therapist diminishes. He/she is no longer considered as the holder of all the rights, as in the case of a tyrannical parent, nor of all the duties, as in the case of an obsessively giving parent.

Neri stresses that the "fraternal community stage" is characterized by the entry onto the scene of a collective subject and by the fact that participants feel they possess the rights regarding the group, (no longer in the hands of the therapist). Each individual has title to the same rights inasmuch as he participates in the "fraternal community"

Contrary to what occurs in re-enacting the archaic fusional phases, here the patients' sense of self and their own special features is maintained. Group members are aware that they are participating together in the analysis and feelings of rivalry, envy and admiration may appear. In this phase, processes of identification and projection occur within the group, activating regressive movements. In this way, as during

adolescence, previous identifications can become de-structured and partially re-projected and re-personified. In the group matrix it becomes possible to modify a pre-constituted system of roles, laws and needs, which conditions the patients' image both of themselves and of the world. Therefore, intra and inter-psychic conflicts tend to be brought to the fore and acted out in relation to objects, which may represent objects of the past or even Self-objects, with a consequent, typically adolescent experience of agitation and confusion. Conflicts are played out more than ever in the "here and now" of the group situation and often the relational modalities acquired in the family are acted out during group interaction. Whereas they are usually so deeply rooted in the structure of the adult ego as to be unrecognisable, in this laborious but potentially positive situation, they are reflected in and by the group and therefore understood, recognised and, according to a given situation, eliminated or integrated. Patients' awareness of having rights and duties, achieved by such hard labour, is exported outside the group and experienced in the social environment, no longer in ways belonging to the area of omnipotence and guilt projected or introjected but in responsible ways, keeping in mind their own and others' rights.

At this juncture we have the impression that patients can finally handle their own lives and face the future without having to resort to a maniacal negation of death. Notwithstanding the professionalism and depth of preparation of analysts, because the theme of death is so meaningful in these groups, it is often necessary to refer to external supervisors. The difficulties faced by analysts are numerous and the involvement required of them is particularly profound and authentic. Therefore regulating the emotive distance necessary to deal in the best possible way with the themes as they come up is particularly problematic.

In conclusion, I would like to recall how important it is, and fortunately now even realistic, to be aware that therapeutic groups for HIV positive patients are, in fact, therapeutic groups and not groups guiding them towards a "good death". I totally share these patients' right to a valued life and to the understanding of the meaning of life before being able and having to face that of death. Just recently a patient who had finished his therapy left as a legacy to the other members of the group, the hope that they too would be able to leave the group because they felt well and not only because they are afraid of the group and flee, or because they are to die. Naturally, this should not involve a denial of death, but the ability to see and face life together, something which all human beings should be able to do despite the hypomanic push in the other direction which we receive from the social environment.

The indissoluble life/death bond is expressed well by Sini: "let us remember that apart from public knowledge, apart from this fact that is thought of as the unthinkable (death), which among other things opens the doors to flights of fantasy, apart from all this, eternally, continually victorious over this thought is the enchantment of life, the enchantment of each instant that faces the thought of death, that alone defeats it in every moment, in an omnitemporality which can certainly not do without death (its other side), but which is no less strong, no less penetrating, no less powerful and, above all, no less human."

I feel able therefore to conclude that the therapeutic group, thanks to the specifics I have highlighted, provides support to HIV positive patients to the extent that it causes the thought of death to restore - or give them for the first time - a sense of self and of their importance as people, a sense of their uniqueness as human beings and allow the passage from the maniacally "infinite" time of the healthy subject to the realistically and potentially limited time of the HIV positive subject to be a passage of more careful examination of the "here and now", of the real positive potentials that life can offer.

References

Ashbach, C, Schermer, V. (1987) : *Object relations, the Self and the Group* - London and New York, Routledge and Kegan Paul.

AA.VV.(1985) : *La morte oggi* - Feltrinelli, Milano.

Balint, M, e E. Ed. Or (1959), Trad. it (1983) : "*La Regressione*" - Cortina, Milano.

Corbella, S. (1988) : La terapia di gruppo, in "*Trattato di Psicoanalisi*" vol.I -Cortina, Milano.

Foulkes, S.H. (1964): *Therapeutic Group Analysis*. London: George Allen & Unwin.

Foulkes, S.H.(1975): *Group-Analytic Psychotherapy: Methods and Principles*. London: Gordon & Breach

Kernberg, O. (1975): *Borderline Conditions and Pathological Narcissism*. (U.S.A.) Jason Aranson Publisher

Kohut, H.(1978): *The Search for the Self. Selected Writings of Heinz Kohut 1950-1978*. (Ed. Paul H. Ornstein): New York: International University Press

Kohut, H.(1984): *How Does Analysis Cure?* Chicago: Chicago University Press

Lazzari, C, Campione, F, Chiodo, F. (1993),: "Aspetti psicologici e sociali dell'epidemia di Aids" in "*Gli argonauti*" n.56,pp.61-76 - CIS Editore.

Maffei, C.(a cura di) (1993): *Il disturbo borderline di personalità* - Bollati Boringhieri, Torino.

Mariotti, G.(1987),: La morte annunciata in "*Nuova unità sanitaria*"n.2,pp. 70-78- Lalli Editore.

Neri, C. (1995): *Group*. London: Jessica Kingsley Publishers

Paris, J. (1994): *Borderline Personality Disorder: A Multidimensional Approach*. (U.S.A.) American Psychiatric Press

Sini,C.(1985): Irrazionalità e morte, in AA.VV., "*La morte oggi*", cit.,pp.69-76.

Wilson, J.O. (1980): *After Affluence: Economics to Meet Human Needs* - New York: Harper&Row,

Zucca Alessandrelli, C. (1995): "Il marchio" in "*Gli argonauti*"n. 66,pp.231-244 - CIS Editore.

Silvia Corbella. Psychoanalyst (SPI), Group-analyst (IAPG). Pastpresident of the A.P.G. Socio Fondatore ARGO. Teacher at C.OI.R.A.G. (Milan and Padoa Institut),

author of many researches, in particular of: di *Storie e luoghi del gruppo*, (Stories and places of the group) Cortina, Milano

Viale Romagna 5820133-MilanoTel-fax ++39-022664216
E-mail : silviricor@uninetcom.it- silviricor @fastwebnet.it