The Individual Psychoanalytic Psychotherapy of Schizophrenia: Scientific and Clinical Approach Through a Clinical Discussion Group

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Received November 26, 1984

Fifty individual psychotherapies of schizophrenic patients, supervised by a control group for fourteen years, are examined. 80 percent of the patients have shown important clinical progress and, in many cases, have been healed, especially those who continued therapy for more than two years and who had a deep and reciprocal emotional involvement with the therapist during and after treatment; there was a reduction by 70 percent of hospitalizations during this treatment and only one of these had a relapse.

Other data confirm the efficacy of psychotherapy; however, to give a new instrument of scientific confirmation to this type of individual and subjective work, we tried to observe how the psychopathological and therapeutic mechanism of "symbiosis" induces personal dynamics in the therapist which are reflected in the control group.

The psychopathological symbiotic disturbance of the patient, the therapeutic symbiotic relationship, and the way in which the group reacts to these permit the creation of a useful triangle, both for the therapist to understand his position toward the patient and to confirm or correct the subjective aspects of such a deep and emotional relationship.

I

The first part of this paper intends to show that the individual psychotherapy of schizophrenia is still an instrument of primary importance both for helping the patient and for a greater understanding of this as yet undefined psychopathological field.

The second part tries to demonstrate how, from a psychotherapeutic relationship between two people, which is so difficult to reproduce because of its complex, prolonged, and "private" nature, it is possible to obtain objective, repeatable, and confrontable phenomena useful for giving a scientific confirmation to this psychoanalytical approach.

To accomplish these two aims the authors use fourteen years of work conducted by them as a discussion and clinical supervision group, under the leadership of G. Benedetti, holding three hour-long monthly meetings in Milan, Italy.

Each meeting was dedicated to the discussion of one particular therapy carried out by a member of the group and written up in advance. After the general discussion, the group leader presented both his previously written assessment and a synthesis of the discussion. All the discussions were recorded in their entirety.

The group1 was composed of fifteen psychotherapists of schizophrenia, all with psychoanalytic training.

1The group is still working.

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The group of patients in the study (Table 1) consisted of 39 cases of schizophrenia in a strictly clinical sense, with primary and secondary Bleuler's symptoms. The authors have added nine episodic schizophrenias and two cases with schizo-affective disorders.

In reality, from a traditional psychiatric viewpoint, the nine and the two added cases would be considered in all effects as schizophrenic patients; in fact, five of them had previously had either pharmacological treatment or hospitalization with a diagnosis of schizophrenia. Only through a long psychotherapeutic observation was it possible to formulate structurally and dynamically more complete diagnoses beyond the apparent behavioral symptomology.

The authors maintain that the psychotherapeutic approach, the long treatment, and the follow-up very often allow a revision of some of the psychiatrically more severe diagnoses.

Through our clinical discussions and supervision it has been possible to observe for all these eleven cases how, beyond the evident dissociative symptoms, delusions of guilt and self-destruction (that is, of a depressive nature) were noticeably present. Also the ego of each was able, to a greater or lesser extent, to maintain an insight into the dissociative and schizophrenia-like disturbance, in contrast to the apparent clinical absence of "consciousness of illness."

In any case, the gravity of the symptomaticity of these eleven patients, the occurrence, at least once, of a long period with symptoms of the schizophrenic series, the dissociated thought and affectivity, and the serious possibility of a chronic condition place these patients in the nosographic psychiatric category of schizophrenia.

The patients' ages range from 17 to 46, but most of them were between 25 and 35 at the beginning of therapy.

Thirty-eight therapies are finished, having lasted between three and ten years, with an average of five years.

Nine therapies, begun at least one and one-half years ago, are still in progress. Those interrupted after about two years are three in number.

Twenty-nine cases had a follow-up of from 1½ to ten years. Nothing more is known about nine cases (in part because the therapist for two cases has died). The sessions
numbered from a minimum of two to a maximum of five per week, with patients for the most part "face to face" in a very adaptable setting, according to each one's needs.

To be precise, all are private patients, treated in individual psychotherapy. In no way, however, does that constitute a cultural or social selection; the patients belong uniformly to all the social classes, from the working class (one patient at the beginning of the therapy was almost illiterate) to the upper class. Some patients are treated free of charge or through public assistance; others pay a symbolic fee appropriate for their insufficient income.

The therapeutic technique was, however, much less rigid than that used with neurotic patients; according to the situation the therapists alternated interpretative interventions with moments of "holding" (in the sense of Winnicott).

First, it seems to the authors that to demonstrate the help of the psychotherapy to the patients the number of hospitalizations and treatments before and during their therapies should be noted (Table 2).

Previous to the therapy, ten patients had had one hospitalization for mental illness, 17 between two and five, and five between six and 20 hospitalizations. Four patients had tried one long psychotherapy before, and four other patients, two or three psychotherapies.

Forty-one patients had been treated with neuroleptics; six had also had electroshock therapy, which is now used in Italy only in very rare and serious cases.

During the therapy, however, six patients had one hospitalization, three between two and five; only one patient had eight hospitalizations. It should be noted that at least half of these hospitalizations were arranged with the therapist in such a way that the patients could value this decision in a dynamic manner. Twenty-two patients continued and one spontaneously started cures with neuroleptics, although, in general, with reduced posology. Of the 29 patients for whom we have a follow-up, only one has had a brief hospitalization three years after conclusion of the therapy.

Table 3 shows, for all the patients, the level of work capability, of acceptance of ordinary social rules and the capacity to have interpersonal relationships with family members, partners, or friends, and the level of acceptance of "the other" before and after therapy. All the cases are included, even those which are still in progress. It has become evident that for eight cases the results are unsatisfactory (with a slight improvement in general, however), while for 42 cases the clinical and affective-relational results are either satisfying or indeed very good, taking the initial seriousness of the illness into account.

This success in 80 percent of the cases might seem high, but it should be stressed that these are cases which were able to continue therapy for more than two years; the authors consider, because of this experience, that if a psychotherapy can continue for more than two years, the prognosis has a good chance of being favorable. Indeed, those

| Table 2 |
|---------|
| Hospitalizations and Treatments Before and During the Therapy |
|          | Before Therapy | Therapy in Progress |
| Hospitalization | 1 | 2–5 | 6–20 | 1 | 2–5 | 9 |
| Psychotherapy | 10 | 17 | 5 | 6 | 3 | 1 |
| Neuroleptic therapy | 4 | 4 | 2 |
| | 41 (6 + E.S.T.) | 22 (reduced) |
cases which have sustained a therapy of more than four to five years have had a frankly favorable development.

Nine therapies begun at least two years ago are still in progress, three were interrupted after about one and a half years, and thirty-eight are finished, having lasted between three and ten years, with an average of five years.

As regards the follow-up, nothing concrete is known about nine patients; however, twenty-nine have maintained periodic contacts with their therapists. Keeping in mind how difficult it is to find objective and quantifiable criteria in the psychotherapy of schizophrenia, the nature of these contacts deserves attention (Table 4).

All the patients, through letters, phone calls, or occasional sessions were eager to show the therapists their social and emotional improvements.

In our experience, this continued contact contrasts with what occurs in the therapy of neurotic patients who,² even after a good resolution of transfer conflicts and the elaboration of the end of the therapy, only rarely have successive contacts with the therapist.

It is interesting to stress that these 29 patients, on the one hand, made remarkable clinical, interpersonal and social improvement (often leading to complete healing) and, on the other hand, demonstrated a high level of emotional involvement in the therapy.

These cases show that there is a correlation between the deep affection of the therapeutic relationship, the clinical improvement, and the maintenance of post-therapeutic contact.

Certainly someone might criticize such behavior as an unresolved therapeutic relationship; perhaps that judgment would be true in cases of neurosis.

In the authors' opinion this maintenance of contact in schizophrenia should on no account be seen as a post-therapeutic maintenance of an infantile dependence. Rather, it should be understood as the realization of the introjection of the therapist's image as a substitute and stable object, which allows the evident improvement and healing. The parallel between the deep emotional involvement of patient and therapist during treatment and the maintenance of a relationship after therapy (29 cases) and the therapeutic success contrast strongly with those affirmations that there is a risk of a "malignant regression" in cases of great emotional involvement. Indeed it can be stated that where there is the possibility of an affective regression, the prognosis is more favorable.

Thus a patient, who had been suffering from a persecutory delusion transformed during the treatment into a worrying erotic delusion toward the therapist, when the

²This refers both to the authors' personal experience and to the more than 70 neurotic cases discussed in the group.
TABLE 4
Post-Therapeutic Contacts with Therapists

|                          |            |
|--------------------------|------------|
| Schizophrenics' reports  |            |
| Discussed                | 25         |
| Not discussed            | 16         |
| Episodic schizophrenics' reports |     |
| Discussed                | 9          |
| Not discussed            | 1          |
| Individual supervision   |            |
| Systemic or episodic     | 40         |
| No supervision           | 10         |
| Discussants              |            |
| (monthly, three hours, 14 years) | 12–16, plus leader |
| Therapists               | 15         |
| (seven women, eight men) |            |

efficacious therapy was over communicated to the therapist from time to time her progressive separation from him to construct her own family.

There is a last prognostic aspect in contrast to the current opinion that the more florid the psychosis, the better the therapeutic possibilities are.

The authors have found no difference of therapeutic evolution between cases with structured delusions and cases with autistic-catatonic symptoms (the so-called “poor” ones); in both situations there is much evidence of the relationship between good results and the possibility of the therapist being involved emotionally from the very beginning.

This involvement can be varied and often linked to the symbiotic dynamics which are discussed later in this paper. The authors would like to emphasize, however, that, when this involvement is lacking, the therapeutic results may be partial, and the therapist ought to realize that something is going wrong in the treatment.

II

The second part of this paper concerns the results and dynamics of the individual psychotherapies, observed mostly through the group’s work.

Of the 41 schizophrenics, 25 were discussed by the group, who had already read a long report written by the therapist and sent previously to all the team; a similar procedure was followed for the eight episodic schizophrenias. Sixteen schizophrenics and one episodic schizophrenia were not presented, some of them for reasons connected with the therapies.

About 80 percent of the cases had individual supervisions, which were more or less systematic. The supervisors were the group’s leader and other experts. Ten cases had no supervision at all.

To enter the heart of the patient-therapy-group interrelation, a central phenomenon of schizophrenic psychopathology and therefore of its treatment is isolated: the genetic-dynamic concept of “symbiosis” both in its physiological aspects and its psychopathological and therapeutic ones as described by Margaret Mahler [1], by Mahler and Furer [2], by Margaret Little [3], by Loewald [4], by Searles [5,6], by Benedetti and co-workers [7], and by Benedetti [8], to cite only a few.

Note that the symbiosis and its derivative disturbances cannot remain, from a
scientific point of view, other than hypotheses where the therapist limits his observations of the symbiosis to the biography of the patient.

These observations acquire more concrete and demonstrable characteristics, at least for the therapist, when he feels himself involved in the dynamic of the symbiosis, particularly if the therapist is able (as it is hoped he is) to keep part of his observant ego outside the symbiotic mechanisms and actions.

Though the therapist feels this involvement, it still remains at an intratherapeutic level of observation, without the possibility of an "outside" control. Furthermore, in the authors' opinion, for the symbiosis to become an observable and verifiable scientific phenomenon, the therapist, in a more or less conscious way, should induce or obtain some kind of response from the group which is related to the process of therapeutic symbiosis.

Examine this symbiosis more carefully: first of all, every therapist in every case has found the presence of the symbiotic needs and fears of the patient.

Second, the therapists felt themselves the object of these needs and refusals. Thus it can be stated that symbiosis is a crucial event in schizophrenic therapy, and it can be considered analogous to the transfer phenomena in neurosis therapy [9]. Of course, for its archaic nature it is an event characterized more by emotion than by object representation and, as such in ongoing schizophrenia therapies, symbiosis can precede the true transfer.

In any case, the authors believe there is a correlation between the occurrence of a symbiosis and a favorable prognosis. Searles [6] schematized five phases: lack of contact, ambivalent symbiosis, total symbiosis, symbiosis resolution, and elaboration of a new individualization.

It must be remembered that this schematic succession is artificial. All of the group came to be involved in similar situations more than once with the variants of course depending on the personalities of the individual therapists.

Therefore in the consolidated therapies, the first phase, that of the patient's contact closure and/or fear, corresponded to a more or less intensive emotional response by the therapist; for example, this response ranged from identification with the patients' needs, through a sense of challenge against the illness, to fear of the enormous unexpressed demands of the patient.

In the second phase, of the patient's ambivalence, the therapist felt an emotional-ambivalent condition of his own (trying, when he could, to observe it); similarly, like feelings occurred in the third and fourth phases of the total symbiosis, where for the most part there was a great emotional correspondence between patient and therapist, and in which the characteristic events of all the phases of therapeutic symbiosis could be accentuated.

In fact, symbiosis, which, because of its archaic characteristics and its connection with very regressive moments of the personality, cannot be recognized by the therapist, can determine his "overresponse," can be acted on by him in connection with progressive or regressive needs of the patient, can be refused in its central aspects and only accepted in its marginal ones, and, naturally, can be understood and accepted completely.

If everything goes well, the fifth phase is reached, that characterized by the elaboration of the symbiosis, by the recognition of the therapist as a real person, and by the structuralization of the object relations. Furthermore, it is hoped, the therapist can be observed on a higher emotional level than his patient.
It is in this complex and deeply involving therapist dynamic that the group, the authors believe, acquires functions which go beyond its well-known didactic ones.

The first of these is observable, in a more or less voluntary way, when the therapist identifies the group as an “outside reference point,” in a type of “real world” outside the symbiosis.

This should not be understood in a superego or didactic way, as described by Ekstein and Wallerstein [10], but in the sense that it becomes a kind of “principle of reality” with which the therapist consciously or unconsciously should make contact.

Two short vignettes illustrate and highlight this situation; they concern the choice of maintaining a clear and understood symbiotic relationship outside the group and supervision.

*Angelo*

Angelo, 34, who has a simplex-ebephrenic schizophrenia with persecution delusions, because through a serious diagnostic error he was placed in an institution for subnormals when he was six and remained for seven years, started therapy with the preconception that he would end inside a long-term psychiatric hospital.

Faced by this sense of imminent catastrophe, the therapist felt the need to give Angelo what he had never had, by means of an idealizing, active, and pedagogical relationship. Her countertransference was full of the sense of injustice against society which had never understood Angelo.

She never brought this rich and complex case to the group, and during this research it became clear that she, unconsciously, had felt the group as an extension of the society which had refused him.

Thus the patient, who had been blocked in the first symbiotic phases and by his early hospitalization, could go through all the symbiotic phases with a therapist who was free from fear-dependence toward society. Now the former patient works in a “trade union,” a job that in Italy requires mature competitive drive.

*Frieda*

The second vignette concerns Frieda, 29, struck by paranoid schizophrenia after three years of marriage and taken in therapy after a previous useless four-year analysis; she alternated idealizing symbiotic identification with aggression (sometimes physical) toward the therapist when he became for her the representative of the evil in the world.

The therapist, despite his “discouragement: for four years I felt myself on a journey without end,” over the years had accepted the very early regressions as a positive sign and never wanted to “expose” the patient to the group. He worked in a very deep symbiosis, sometimes even preparing food for the patient.

After six years of therapy, the patient returned to become an excellent wife and mother and a competent professional person; since then (two years ago) she has maintained close contacts with the therapist, but she attributes her “salvation” to the encounter with him as a person and not with him as a therapist. The cure was consolidated by her choice of work in a psychiatric community to get “herself” out of the symbiosis and not to be taken out by “her therapist,” this action signifying the “giving” rather than the “receiving.”

It is the authors’ opinion that the patient has closed a circle which includes the
therapist's decision that no one else intervene in this therapy, thus giving to the patient herself the right to choose her own control group, that is to say, the therapeutic community.

The second way in which the group becomes a fundamental element of the therapeutic relationship is by offering the opportunity to pass from a symbiotic relationship that emphasizes the emotional and identificatory processes of primary thought to a relationship that is based more on the processes of secondary thought.

This process often corresponds to the therapist's evolution from an ambivalent phase to a phase of total symbiosis or from that phase to one of individualization.

Two brief examples follow.

Silvia

Silvia, 40, alternated between autistic moments and reference delusions; she identified six different persons in herself, in an atmosphere of great confusion which nevertheless did not put the therapist in a difficult position. That stage occurred when the therapist had to present the case to her supervisor; before the session she felt that there was nothing to talk about, only to realize afterward that she had presented rich and productive subjects. This realization, little by little, showed her how deep her symbiotic identification with the patient was; the patient, at the start of the illness, had left the medical profession to isolate herself at home, to live in a silent relationship with her mother, only writing beautiful fables. The therapist found herself as mute with third persons as her patient was.

During this research, moreover, the therapist observed how her failure to present the case to the group but only to present it in individual supervision with the group leader was caused by her identification with the patient's great number of imaginary people; the therapist would never have tolerated extra-identificatory processes in a large group.

The Therapists

The next example concerns three therapists who said that, before writing the reports of their three cases, they were in a phase of perfect well-being with their patients in spite of a total lack of comprehension of the dynamics in progress.

When they were writing their reports for the group discussion, however, they suddenly understood the dynamics, which included the manipulatory ones of their patients against them; these manipulatory tendencies of a progressive or pre-phallic nature were covered by the symbiosis, probably because of a reciprocal fear of aggression. It seems that the therapists were unable, except by taking the group into consideration, to transfer into words what they felt at a preconscious level during the therapy.

The tape recording of the discussion reveals some aggression on the part of the group counter-identifying with the patients and the therapists.

III

These two examples introduce the last group function of those presented here; that is, that which demonstrates the symbiotic interrelations between the patient-therapist pair and the group.

The authors maintain that it is always possible to see a correlation between the
patient's primary symbiosis, the therapeutic symbiosis, and the symbiotic dynamics between the therapeutic situation and the group.

The observation of these three dynamics (that is, the interrelation between the three moments) that can be defined as (1) etiopathogenetic, (2) relational, and (3) social, not only intervenes directly or indirectly in the management of the therapy as a confirmatory or mutative factor, but the interrelation of these three dynamics also offers the possibility of confirming clinical and therapeutic hypotheses through a triangulation process.

Until now, psychotherapeutic theory and technique have found confirmation by paralleling the patient's personal history and the events of the therapeutic setting; by this is meant the transference and the countertransference as a confirmation of the functioning and the history of the patient.

Now the authors think they can introduce a third element for scientific confirmation: the group, which becomes an extension of the patient's life story, actual and past needs, and, moreover, of the conscious and unconscious movements of the therapist— that is to say, of the therapy itself.

This last hypothesis, together with the criteria of traditional clinical psychiatry, could represent a further way of evaluating, quantifying, and scientifically confirming the phenomena relating to the psychotherapy of schizophrenia.

In the authors' opinion these three dynamics are determined by complex identificatory and projective phenomena and only slightly by the inevitable internal group dynamics or the particular problems of the therapist; when these happen, they are easily observable.

These dynamics occur not inside Bion's or Balint's group dynamics, but inside dynamics induced by the patient-therapist interaction.

Thus the authors believe that it is important to understand that the group acts and reacts in a functional way that is affected by therapeutic events and by the pathogenesis of the patient; that is to say, the group repeats or contrasts the progressive or regressive situations and needs of the therapeutic pair, and thus of the patient.

Eduardo

Eduardo, 25, was presented to the group by the therapist only because there were no other cases to discuss. He was a very regressed patient who came from a family that had always expected too much of him.

The case discussion was unsatisfactory and a large part of the group was divided; some tended to overprotect the therapy, others wanted to give different and contrasting kinds of advice. In short, it is evident that the group reacted in different ways because of its own need to function in the best possible manner.

The therapist left the discussion confused but decided, thanks to those contrasting opinions, not to change her therapeutic relationship which was, in fact, good and efficacious and continued to be so.

The patient, who had had early bruising of his ego function and in fact did not have great intellectual powers, little by little accepted his handicap, got a job, and opened relationships suitable for him.

Despite great improvement, however, the patient's parents, acting out their own pathology of not accepting their son unless he fulfilled their grandiose expectations, interrupted the therapy after three years.

In summary, the whole therapist-group situation had exactly repeated a central
element of the original pathology of the patient and of his family; the therapist, to protect the group which had to continue to work and meet, and thus not primarily for the needs of the patient, had presented him to the group, “pushing the patient outside” the therapeutic relationship.

The group reacted with a “lack of contact” situation; that is to say, a regressive situation, to the premature rupture of the symbiosis by the therapist, just as the patient had been prematurely pushed toward maturity by his parents.

Mario

The case of Mario also helps to clarify this third point of the group’s functions.

Mario, a thirty-year-old lawyer, because of his pathology was only able to function as a very ordinary factory worker.

During therapy sessions he alternated the supposition that his mother wished to hinder the therapy with the conviction that the therapist did not want to help him. The therapist on his side contained the patient’s great aggressiveness very well, with much empathy. A few years later, after the end of the reference delusions based on narcissistic drives, the patient no longer had insight nor collaborated during the therapeutic sessions.

The therapist introduced the case in the group discussion, admitting that his difficulty had arisen over the previous few months out of a sense of boredom and his indifference to the patient.

During the discussion it came out that the patient autonomously had begun to study again and was returning to his previous social status. The therapist, too involved in observing the intratherapeutic events and dynamics, had not given enough importance to the great effort and difficulty that the patient was putting into this comeback; in short he had not placed enough importance on what was happening outside their relationship.

All this was clarified in discussion and in the leader’s final report. It is also interesting to observe, however, that at first the group reacted in a reassuring way to protect the therapeutic relationship from the latent aggressiveness; then it pointed out to the therapist, in a superego manner, the need for him too to widen his observation, and to progress in abandoning some of his own narcissistic expectations.

The patient progressed with much less effort and, naturally, the therapist’s boredom disappeared.

The therapist had reacted with boredom to the frustration of some of his narcissistic expectations from the therapy, erroneously remaining tied to an obsolete symbiotic phase. Thus in a mirror-like way, the group reacted to the therapeutic situation and the patient’s condition, at first in a regressive manner, and then in an over-progressive one.

In that therapeutic situation, concluded satisfactorily, it is possible to observe the more general therapeutic dilemma which reflects a central problem of symbiotic pathology: “I cannot accept you as you are,” conflicting with “I can only accept you if you stay as you are.” This problem often reverberates in the group, creating divisions; some are too ready to give technical criticism and advice while others overemphasize the positive aspects of the therapy. Generally this happens during the first phase of the discussion.
It must be stated that the clarifications of the group do not necessarily lead to substantial changes in the therapist's behavior and strategy. On the contrary, if that happens too quickly, as it did in one difficult case, where the therapist felt insecure, the suggested changes can induce a failure.

Moreover it should be added that the therapist, despite a good level of discussion, does not always feel that the group has fully understood what is happening between him and his patient.

In this regard it would be interesting in subsequent research to observe if this dissatisfaction might not derive from a lack of observation of the group dynamics explained here.

The patient's symbiotic pathology and therapeutic symbiosis contain emotional elements which are so strong that they cause clear reactions in the group, but, especially because of these, they must be evaluated accurately.

Indeed, a 25-year-old patient was in a perfect symbiosis with her therapist who accepted the patient's delusions and hallucinations as a pretty artistic creation and not as pathological symptoms.

Most of the group severely pointed out the psychiatric seriousness of the case; only the leader and few others tried to understand the relationship. The discussion was dominated by those who felt themselves to be the "upholders" of theory and technique.

It is important to underline that the pathology of the patient was that she felt herself surrounded by a membrane which saved her from a life full of dangers, and she even enclosed her therapist inside this membrane—which also saved the patient from an overprotective and directive mother.

The group did not realize that it was identifying itself with the mother in a projective way; on the contrary, it accused the therapist of that identification. The therapist left the discussion, upset that she had not understood the seriousness of the case and decided to revise her therapeutic strategy; the therapy went badly.

Only after the elaboration of the countertransference induced by the group did the therapist reacquire her previous tranquillity and accept only some of the group's suggestions. The patient finished the six-year therapy in so satisfactory a manner that now, with a husband and two children, she can calmly cope with a serious illness that is making her blind.

In conclusion the authors emphasize that the group can be a third stage of confrontation between the pathological symbiotic dynamics of the patient and the related events in the therapy.

Observation of these dynamics, as well as contributing to the better understanding and insight of the therapist, offers the possibility of verifying scientifically and not just subjectively the etiological and therapeutic hypotheses of schizophrenia.

The authors believe that the possibility of deepening the responses that a work group gives to a schizophrenic patient and to his therapeutic relationship can help to provide new hypotheses on schizophrenia or schizophrenias and its or their relationship with the social environment.

Thus, the authors see a possibility of establishing a bridge between the individual psychotherapy of schizophrenia and its psychosocial treatments; this bridge could be constructed by studying the kinds of responses that society gives the sick person, responses which can, contrary to their reasonable appearance, actually harm that sick person.
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