The group activities in the Diagnosis and Treatment of Psychiatric Services

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Abstract
In all the western countries has established the model of community psychiatry. In this model, the aims of the wards for acute pathologies (Psychiatric Emergency Services) are slowly passed from the historical ones, of the control of agitation, anger and despair, with the limitation of the most disturbing expressions on the social level, taking no notice of diagnosis and evaluation of the causes of the crisis, to the most modern ones, which measure the quality and success of an inpatient acute psychiatric ward not on the number of patients seen and stabilized, but instead entrusted with success in long-term therapy project.
In this perspective, the group activity within the Italian Diagnosis and Treatment Psychiatric Services (SPDC, the inpatient acute psychiatric ward of the NHS) takes a significant value, both for the management of the emotional atmosphere inside the ward, that for the development or the reinforcement of those social cognition skills that will be, at discharge, decisive for the recovery of adequate cognitive skills.
The article is the exact transcription of the lesson happened in 2012 within the course of Theory and Practice of the Intervention in Groups, at the Faculty of Medicine and Psychology, Sapienza- University of Rome.

Key Words: SPDC, group, metacognition, emotional regulation, compliance/continuity of the therapy.

Introduction
The Italian Diagnosis and Treatment Psychiatric Services (SPDC) are about 300 and represent, even in their variety of styles and features, an eloquent indicator of the evolution of psychiatry. In fact, as well described by the research PROGRES (De Girolamo, 2007), the wards for acute pathologies (Psychiatric Emergency Services) are no longer intended only for the control of agitation, anger and despair, without considering the diagnosis and the evaluation of the causes of the crisis, but aim to build, in the continuity of the therapy and with the help of local services, long-term therapy projects.
Even in the short time of the recovery, they have become places for the development of those relational, emotional and cognitive functions essential to a person, whatever the diagnosis of the hospitalization, for the observance to the treatment and to be reintegrated in the social context.
At the same time, the SPDC are a crucial part of the changes in society and health care organizations: transformations that have produced new psychiatric emergency
scenarios, as the epidemic of drugs abuse, behavioral crises of disabled adults, the mental disorders in emigrants, the borderline disorders and antisocial behaviors, the increase in demand for social control, which is opposed to the increasing poverty of local services, the development of metropolitan areas and the problems related to them.

The SPDC is a ward set up within general hospitals after 1978. It has a maximum of 15 beds, although, in reality, there are some which have 20 (a larger number necessarily involves a shift to institutionalizing strategies that trace the path of the asylum). It is the place in which are carried out the obligatory health treatments. In Italy you can make obligatory health treatments in two cases only: mental illness and contagious infectious diseases. In both cases the required obligatory treatments must be ordered by the mayor, who is the highest local health authority. The TSO is an important tool, because the real problem for those who make the psychiatrist is represented by difficult, young, uncooperative patients (De Girolamo, 2008).

In Lazio there are 22 SPDC, with 269 beds, plus 23 beds in Day hospital. The Mental Health Law 1998-2000 says there should be a bed every 10,000 inhabitants. Currently in Lazio the proportion is 0.48 beds per 10,000 inhabitants, with an uneven distribution. For example, in the area of SPDC San Filippo Neri reside 374,000 inhabitants, with a proportion of beds/inhabitants of 0.29, much lower than the proportion, already low, of Lazio. This has very serious consequences on the continuity of the therapy: since most of the inhabitants of Lazio lives in Rome, many patients are hospitalized and transferred in SPDC in the province, as Sora, Subiaco and Cassino, generating a phenomenon that I call “psychiatric tourism”. This phenomenon is analyzed with different tools of institutional analysis, such as the monogram of Gandy, which allows us to understand the capacity of services to meet the demand of its territory or of people coming from the extraterritorial zones.

The SPDC is a place of great contradictions, as the use of mechanical restraint, contradictions also determined by the scarcity of resources and means with which we operate (as we have just seen). All the patients who are admitted to a SPDC are evaluated according to the principles of the risk assessment and the management of risk escalation of aggression should provide for a growing set of specific strategies. The first of these is represented by the emotional regulation and the de-escalation, which includes techniques such as the talking down and the active listening, as well as non-verbal strategies and specific methods of spatial intervention. A primary role is also played by group meetings oriented to the model of the assembly in the first therapeutic communities, meetings in which the patients can express criticism, needs, demands, and thus lower the level of claim and tension, which often represents the trigger of the aggressive escalation. Yet, in some situations, these strategies are not enough, especially if we deal with people who, for example, have made use of unknown substances and are in the grip of an uncontrollable agitation. When it is not even possible to intervene pharmacologically, unfortunately, in these cases, it becomes necessary to contain.
In this complex context, of lights and shadows, the development of group activities within the SPDC for the hospitalized patients is a quality key element for the priority aim of the recovery.

**Schizophrenia and other disorders present in SPDC**

Before considering the merits of group activities in SPDC, however, I would like to talk about schizophrenia. When we talk of group experience in SPDC necessarily we refer to schizophrenia, the understanding of which represent the keystone of the whole mental health.

For this purpose, I would like to quote an article by Jim Van Os (Nature, 2010) published in a very prestigious magazine. This article makes a fundamental contribution to describe and demonstrate the interactions between the environment and schizophrenia. Clinical psychologists care about environmental influences in particular, which also include the psychotherapeutic relationship as a two-way relationship. Even a disease, and I call it that way because there are very strong evidences of biological and genetic component of schizophrenia, is strongly influenced by the environment.

The latest findings on risk factors allow us to understand how some environmental conditions, including a group experience, can become a protective factor that has a positive effect on the course of a disorder such as schizophrenia. We must not think that the group experiences and the psychotherapeutic relationships can have beneficial effects and are indicated and effective only on diseases in which the psychogenic component is greater than that somatogenetic one: it is not true at all.

There is no longer any difference between what is psychological and what is biological, because what is psychological is biological and what is biological is psychological. Van Os describes a person's life, from birth to twenty years, in relation to the impact of risk and protective factors and their multiple interactions. Risk factors are divided into pre-natal and post-natal. In particular, there are relevant post-natal risk factors, because they are the ones on which we have more evidences. The cannabis smoking is, at this moment, the main biological post-natal risk factor for the development of schizophrenia (and not just of schizophrenia). It is no longer possible to support the idea that the "joint" is a soft drug or that it has never hurt anyone. This is related to several reasons. First of all, the modern joints are very different from those of 30 years ago, because the content of THC, the active ingredient, is 20-30 times higher, because there are no other alkaloids present in the naive plant, as cannabidiol (which is proposed for the cancer therapy as analgesic and relaxing) and especially because the consumption of cannabis is different from that of other drugs, it is an early and continuous usage.

In Italy approximately the 25% of people who are between 15 and 30 years make a constant, almost daily, use of cannabis. Just imagine a 12-13 years old boy at the beginning of pubertal development; imagine, too, that he suffers from a polymorphism of the COMT gene that makes him less able than others to catabolize dopamine. This
is sufficient to cause a serious damage to the brain, with the risk, not only of the amotivational syndrome, namely a frontal damage, but also the development of schizophrenia, especially in the presence of a genetic favorable constellation.

The second post-natal risk factor is represented by traumas, the main trauma is neglect, which includes not only traumatic experiences such as abuse or mistreatment, but also parental neglect (both physical and emotional), and that is expressed as deficit for the care. We refer to the primary caregiving: to that child who is not picked up, no nourished; and then, when it is a bit older, nobody looks how he is dressed, if he is washed, if he ate, what he brings in the backpack, etc. The other two major risk factors, which increase significantly, from 3 to 10 times, the risk of schizophrenia, are living in an overcrowded urban context and being part of an ethnic minority who is not integrated, or a minority group anyway. These factors have multiple demonstrated effects and described in several studies and reviews (Couture et al., 2006; Galderisi & Maj, 2009; Lancaster et al., 2003; Nasrallah, Tandon, Keshavan, 2011). These effects include:

. the brain structure (neurogenesis, organization of the gray matter, axonal growth, myelination, synaptogenesis, synaptic pruning, neuroendocrine regulation);

. neurocognition (sustained attention, selective attention, working memory, language, analogical reasoning, metacognition);

. affective dimension (basic emotions, complex emotions, emotional regulation, reward experience);

. social cognition (emotion recognition, attachment, identity, theory of mind).

These factors, obviously, have a finding also in morphological and functional terms. It is possible to detect deficiencies in all these areas through specific neuropsychological tests. For example, in neurocognition are highlighted problems in some areas that have now become almost pathognomonic of schizophrenia. Pathognomonic means that, by themselves, make a diagnosis in some way, such as the deficiency of the working memory (Heckers & Konradi, 2010).

Another important aspect, regarding the function of the group activities, is the presence of a marked deficiency in emotional consonance and social cognition (Allen et al., 2007; Bowie & Harvey, 2008; Green & Leitman, 2008) in schizophrenia, not only for the effect of the genetic constellation of vulnerability with which a person is born, but for the effect of these risk factors.

Starting from the studies of Galles (2003), Rizzolatti & Sinigaglia (2006) on the mirror neurons, our knowledge today is surely greater. The mirror neurons are motor neurons that are activated when we see or hear one of our conspecific do something. The motor neurons of the brain involved in a movement, for example, are activated in...
a minor number than required to determine the real movement. But if I look at the face of someone who is drawing a smile, the motor neurons that are involved in the smile, also get activated in my brain. The advantage is that these motor neurons are associated with feelings as to say with the emotion, the sense motor feeling connected with a smile, so, I will feel that emotion at the same time I see one of you smile.

Why the motor neurons should help us to feel what the other feels? The relationship between action, perception and cognition is very complicated, based on a circular causality: this type of relation is linked to the embodied cognition in which the embodiment is considered both as a biological and an experiential structure. This is the basis of the ability to share different forms of knowledge, motor, social or emotional. Gallese (2003) postulates the existence of a multiple transversal sharing system in imitation, empathy and mentalism supported by a specific functional mechanism, the embodied simulation, based on the presence of different mirror systems as a basic organization of our social brain. The cognitive processes, therefore, are neurally based on a physical structure and closely related to subjective sensory-motor experiences (Damasio, 1999).

There are two types of patients who have or don’t have a strong limitation in this emotional consonance. One consists of the autistics and the other of the schizophrenics. This deficit is a problem, for example, for the purposes of emotional sharing within a group: it is necessary, therefore, make a mediation of relationship even within a group (we shall see this aspect later). Think about making a therapeutic group in which we deal with the emotions of schizophrenic people or with any other psychiatric diseases, we don’t have any ability to control the settings and there is no chance of getting a resonance/sharing/emotional circularity that is the basis of the changes.

I would also like to remember that the action of risk factors, but also the action of protective factors, is expressed after birth, with mechanisms that are basically epigenetic. What is the epigenetic? Let’s imagine we have a gene sequence that encodes for a certain protein, so I will have a sequence of nitrogenous bases: each triplet an amino acid. If I have that genetic sequence, in some circumstances my DNA will open allowing the binding of RNA and synthesis of that protein. This is the basic mechanism. To this are associated other mechanisms that regulate and modulate protein synthesis and these mechanisms depend on the chemical state, which is also, simplifying a lot, the emotional state of the person who has that kind of sequence. These phenomena, which do not act on the sequence, that is to say, do not alter the genes, but their expression, are called epigenetic phenomena. In reality they are widespread and appear in every kind of disorders, but also of changing and healing, and obviously also significantly affect the brain.

I'll make a very simple example: let’s consider a group of normal people who have never presented problems of psychic nature and expose them to a catastrophe. In good percentage, many of these will develop a post-traumatic stress disorder, that is to say they will have a disorder characterized by nightmares, insomnia, intrusive memories, anxiety, and so on. If we would make a brain morphologic MRI, we would see that the hippocampus of these people has decreased in volume and, if we go a bit
more in detail, we would see that also the synapses have decreased, as if these neurons were impoverished and probably some are also disappeared. If we attend these people - and we can treat them with a psychotherapeutic intervention or we can treat them with a medicine (for example with medicines that inhibit serotonin reuptake, as to say new-generation antidepressants) or, even better, with both of them, we see that these people feel better from a clinical point of view, but if we make another MRI, we will also notice that the hippocampus has grown, its volume has increased and new synapses are formed, as if these cells were flourished again.

What has happened? At the beginning the anxious activation determined a series of changes at the biological level, including, for example, the rise in cortisol that caused a direct methylation of DNA or a methylation of histones. Histones are proteins on which envelops the chromatin: they are not just a support but have the function, depending on how they are arranged in the space, to make accessible or inaccessible some parts of the DNA. This means that the inaccessible parts do not replicate, as if those genes were not there. This means that if those genes are the genes that synthesize for new synapses, if I not synthesize proteins that form new synapses my brain remains stationary, I don’t memorize, but mostly I get impoverished and stiffen, it is what we call the rigidity of the symptomatic behavior that is closely connected with a biological function (remember that the brain is plastic, it is constantly changing, for example after this meeting we will all have a structurally different brain: the long-term memory are new synapses).

On the contrary, through a therapeutic relationship, a holding relationship that, in some way, can allow the person to feel the closeness, the emotional consonance, it sets in motion a process of transformation that changes the climate of the biological cell and creates the acetylation of histones, making the DNA more accessible or making available those parts that were inaccessible with the reactivation of the synthesis of some proteins and the change in brain structure. These processes occur with rapidity, occur even now, at this moment in our brain. Imagine within a therapeutic relationship or caused by the effect of a treatment. We are talking about phenomena that take place continuously in the course of life, then let’s put aside the old idea of static brain, of the perennial neuron. Our brain is plastic, and this is the reason why people who continue to use their brain definitely have less risk of Alzheimer’s, that is a degenerative disease with strong genetic components.

Risk factors, protective factors, brain plasticity, epigenetic mechanisms, and resilience are central aspects and connected to each other in the understanding and treatment of mental illness. Propose a adequate nurturing and attachment, especially in the early stages of existence, work on the structure and quality of the social network and social integration are processes that do not have only a clinical implication, they not only have a an institutional value for our life, for our social cohesion, but they also, and above all, have a preventive and therapeutic function. Building cities in which it is possible live, is a protective factor for our brains.

What are the most frequently disorders in SPDC? First of all, the serious mental diseases like the disorders of the schizophrenic spectrum (spectrum because it also in-
cludes schizoaffective disorder and chronic delusional disorders), the bipolar spectrum and acute personality disorders. Clearly, the common emotional disorders are not present to a significant extent, they are very rare and usually depend on erroneous admission diagnosis. The SPDC also includes emerging diseases such as the eating disorders and the abuse of substances. Please note that all the modern drugs, with the exception of heroin, are substances that produce psychosis. Heroin, on the contrary, is an excellent antipsychotic. After the outbreak of the AIDS epidemic, around 1985, we have witnessed the cultural shift from flash drugs (i.e. that genital orgasmic sensation that lasts a few seconds and that is followed by the feeling of atharaxia that lasts up to several hours) to the hoot drugs that instead are consumed together, which promote the performance.

Finally, there are borderline problems as dementia, mental retardation, sociopathy, delinquency, emigration, as well as the problems related to the ethnicity that involve social exclusion as an element of risk.

**The group activity in the SPDC**

The SPDC is configured as a sub-intensive care unit in which, from the beginning, we try to achieve the consent to treatment, to make a pharmacological therapy for the crisis, but also to build a path and a therapeutic continuity. It would be a mistake to think the SPDC simply as a place to contain the crisis: it is a place where begins a path. Very often the recovery represents a turning point in a person's life, it marks a before and an after, requiring an awareness of the need to make a change in their habits of life and their way of life. The path is customized to the characteristics of the patient and proposes and integrates a variety of interventions: pharmacological, psychological and psychoeducational interventions, interventions on the family, social context and working context because, often, these people develop a crisis in relation to their work environment. In this sense we say it is a therapeutic path characterized by an early rehabilitation.

How is it organized a day at the SPDC and what is the space of group interventions?

After a moment of exchange of views and information on patients, every patient has an individual examination. In any case, all patients are seen every day so there is a constant monitoring of the evolution of their conditions. At this point there is the group experience, which can be either a verbal group or what we call ward assembly: the patients are asked to express their opinions and criticisms about the admission which may relate to the food, the cleanliness of the bathrooms, issues related to the other patients.

After this there is a clinical meeting, followed by other meetings and interventions of various kinds. It is important to consider the SPDC as part of a Department of Mental Health, which makes central the theme of a therapeutic continuity through a direct and continuous contact between the ward’s team and the team of the Department of Mental Health of reference. The people admitted are seen by the staff (doctors, psychologists, nurses, social workers) who work in mental health Centers in order to
maintain this continuity. The visitors entrance is in the afternoon: with some of these there can be structured interviews.

From 4 to 5:30 p.m. restart the group activities, which can be various and which we will describe in more detail later (welfare groups, groups aimed at increasing the meta cognition and the social skills, psychoeducational groups, drawing, cooking, reading newspapers groups).

The group activities have been, over the years, and are still now, quite different since some of these groups are assigned to nurses (those in the afternoon), others are entrusted to psychologists (interns and/or volunteers) with a large turn over of people. This represents a good thing on one side and on the other a problem, because when a person goes away, even that competence goes away. So some groups (particularly those in the morning, more structured) are guaranteed with co-conduction and training, particularly for trainees, which allow its continuity. The afternoon groups are often the result of a personal project and in some cases are created on previous experiences. They try to have a link between the activities done in the morning and in the afternoon.

The day ends with another entry of visitors and finally there is another group moment, but only of greeting/sharing: between 8 and 8.30 p.m., along with the nurses in the common room, they drink a chamomile tea or herbal tea. This is represents the end of the day, which is ritualized. Note that our patients, unfortunately, for invertebrate hospital habits, dine at 6 p.m. and this means that at around 8.30 p.m. is time to go to bed. The chamomile group is, therefore, an almost familiar moment that, somehow, tends to humanize the situation of the recovery.

**Group as mediator of the relationship**

**Group as a vehicle of the concrete dimension**

Why do groups in SPDC? Why work with patients in a group? A first reason is related to the need to offer common areas to share various activities: times and spaces through which approach and relate to the others while keeping a safe distance, without fielding specific social skills. This is especially useful in relation to deficits in social skills, especially for patients with schizophrenia, but that we can also find, in terms of theory of mind, even in patients with bipolar disorder and acute BPD personality. These three categories represent most of the time the 95 % of the admitted patients to the SPDC. These patients, as already mentioned, have difficulties in identifying effective interpersonal behaviors and source of reinforcement compared to specific social contexts (Walter et al., 2011).

It might seem senseless to suggest group activities to people with poor social skills: actually, the group context is less demanding of a normal relationship between two people if it is structured on a size of concrete making. And so the group through various activities (drawing, newspaper reading, movies, cooking) is in some way, a mediation of the relationship with our patients: the shared activity compensates, alt-
hough temporarily, metacognitive and social deficits, offering sustainable relational
experiences. The concrete dimension is one of the constituent elements of then Social
Skill Trainings for the treatment of schizophrenia; the concrete dimension is used as
an informal context in which, step by step, train and coach to several social skills
through processes of modeling, reinforcement, shaping, automation and generalization (Bellack et al., 1997; Bustillo et al., 2001; Roth & Fonagy, 1996).

**Group as vehicle for somatic dimension**
The acute psychiatric patients admitted live often experiences of negligence of the
body and of their physical well-being; in addiction to take care of the body becomes a
way to take care of the whole. It is called synecdoche, the part for the whole: thus, in
this case, we make a synecdoche. Psychiatric patients have many physical problems
which are partly primitive and partly are secondary to treatment. The Wellness
Group, created in the ward, allowed us to intervene in this way: patients are encour-
aged to talk about how they take care of their body, how they eat, how they move,
how they walk, run, how much time they dedicate to sport activities and to the care of
the body. Are elaborated and discussed proposals for change regarding these different
areas stressing that a proper care of the body has remarkable effects on other aspects
of their lives. The Wellness Group faces, in a systematic way, the smoke and the ef-
facts related to it. The majority of psychiatric patients smoke because nicotine has an
antagonistic action in comparison to antipsychotic medicines and drink a lot of coffee
for similar reasons. So the ritual of the psychiatric patient is that of coffee and ciga-
rette. Smoking 60 cigarettes per day (this is the average of cigarettes in psychiatric
patients) represents, of course, not only a high risks in relation to the occurrence of
certain diseases such as lung cancer or cardiovascular problems, but promotes, inactiv-
vating the psychiatric medicines, the possibility of increasing the dosage of the psy-
chopharmacological drugs. Increase the dosage mean increase the side effects: it cre-
ates a vicious cycle that make the disorder chronic rather than cure it. Then work on
tobacco smoke or on excess of coffee is a way to help patients to take a smaller
amount of drugs. Reconsidering the concept of synecdoche, it is clear how to talk of
smoking is to speak of the anguish and anxiety that determines the need to smoke,
talk about nutrition means to talk about their life and how to regulate emotional states
without using food; talk about physical activity is to talk about enjoyable activities .

**Psycho-educational group of cognitive-behavioral type**
The pioneers of the group activity in the SPDC where the SPDC of Campobasso, di-
rected by Franco Veltro, and the one of the San Filippo Neri in Rome, directed by
me. This initial experience of psycho-educational group, and the research related to it,
was incorporated into a manual (Vendittelli et al., 2003) and has spread in many other
Italian SPDC.
This group intervention was developed in the field (using the focus group) and then manualized using a biopsychosocial approach dimensional approach to psychiatric disorders and applying techniques of cognitive-behavioral nature. The theory behind this type of activity is that the patient is the best expert of himself and of his disorder: so the main goal is to make the patient aware of that in order to achieve an active and informed participation to the path of healing.

The biopsychosocial and dimensional approach allow to consider the disorder, not just as a set of appeared symptoms (almost inexplicably) to cure tout court, but as a condition characterized by emotional, behavioral and cognitive responses that are placed along a continuum that leads to coping strategies more or less functional and effective in relation to stressful life events. This approach allows to operate a "normalization of the symptom" in a context, such as that of psychiatric disorders, where the patient's condition and, most of the time, the brevity of the recovery would not allow a clear diagnosis that would be, however, far from the subjective experience of the patient. Rebuilding the reasons for hospitalization and the context of the crisis, normalize the symptoms and hospitalization in a shared space with other patients facilitates the access to the internal experience of the patient more willing to tell his experiences that could be, instead, silenced.

All of this is extremely important in terms of adherence to the therapeutic path. The adherence implies a motivation, an awareness: the patient accept the various measures proposed, from the pharmacological one to the psychotherapeutic one, because he knows that they do well and help him to avoid a relapse.

The compliance concerns instead the fact that the patient does what the doctor tells him to do, so, if he must take the medicine, he takes it. This is the fundamental difference between adherence and compliance: the patient can be cooperative because there is someone who administers the medicine every night, but without being adherent; a patient is adherent when he is the protagonist of his own therapy. The 80% of patients with schizophrenia, one year after starting the treatment, interrupted it and this means relapses, decreased quality of life, worse prognosis. Prevent relapses is a key aim to achieve.

The group interventions refer to the individual cognitive-behavioral treatment of psychosis based, precisely, on a vulnerability-stress-coping model (Casacchia & Roncone, 2000, Chadwick et al., 1998; Kington & Turkington, 1994; Falloon, 1999; Fowler et al., 1995; Fowler et al. 1998; Perris, 1994, Pinto et al., 1999) and, therefore, on an intervention that integrates the psychological and pharmacological treatments with the learning of social skills.

The psychoeducational group intervention is divided into four constant modules and in some optional components that may be included by specific requirements of patients and / or problems (alcohol, hallucinations, anxiety and fear, psychotic thinking, sadness and joy, anger, secondary gain, suicide and TSO). The constant modules are: what happened before the hospitalization, the stress-vulnerability model, psychiatric drugs and the early signs of crisis. The group consists of patients who are at different stages of the recovery: this may be a further advantage because it amplifies and
strengthens the ability to deal with people who have similar difficulties and experiences. Patients who are at the end of the hospitalization may represent a source, certainly more reliable, for the new patients about the usefulness of the therapy or the possibility of living the recovery as an opportunity to stop, understand, and then set off or even to consider the TSO not as an injustice but as a necessary tool. The peer comparison with people who have the same experiences favors the formation of a climate of acceptance and cooperation where the patients themselves may feel effective when they are able to interact and help each other.

It promotes the activation of the cooperation system with a dual effect. First of all working together prevent the activation of the dependence system which, often, involves a disorganization in these patients with a collapse of the already deficient meta-cognitive skills (Liotti & Farina, 2011; Semerari, 2003). A sense of effectiveness, in the second place, derives from the use of a maieutic approach: the patients are the protagonists of the meeting. It is proposed them to retrace the critical event that led to the hospitalization trying to identify the thoughts that accompanied those moments, the emotions and the behaviors associated with activated to cope with the situation. The critical event is defined as stressful: we build together a definition of stress. We explain to them the vulnerability-stress model: stress is a condition experienced by everyone even if at different levels. Together we think about the factors that can increase or decrease the possibility of tolerating stressful situations and which coping strategies to use and learn.

We work on the identification of most stressful psychosocial factors for each patient and on the ability to identify the warning signs that precede the crisis in order to prevent it with appropriate strategies. The last constant module regards psychopharmacological drugs: the patients tell the therapies they are using and this is the starting point to understand together how they work, the various categories and the possible side effects. It often happens that a patient calls the other in group activities; most of the time there is a genuine familiarity between patients; and at the same time it is possible to find the presence of relational tensions, paranoid experiences and aggressive reactions. The modulation of increasing emotional tension or the control of aggressive behavior require a valid training course for controllers and of an appropriate phase of mentoring: even these situations, if well managed, can become a source of learning for the patients. The controller has a central role in creating an shared environment that each one feels to tolerate: a space in which it is necessary to create balance between giving time to search for words that tell what happened and offer a listening time in which dilute the emotional activation.

Also, the controller and the co-controller become facilitators of the interaction so that, given the difficulties of these patients, the group experience does not become a failing and frustrating experience. All the patients are invited to the group but greeted in their eventual rejection that is understood and contextualized.

The techniques used are cognitive-behavioral such as the modeling, the role-playing, the problem-solving, the positive reinforcement, the cognitive decentralization and the use of specific communication skills (active listening, language in first person,
make requests in positive way, the timing of the response). The modeling is one of the most effective aspects in this type of intervention: modeling among similar and modeling between controller and patients, especially with regard to specific basic social skills.

The function of mirroring between patients is, as already emphasized, a strength point for the group work, at the same time, in this specific type of intervention, the controller must modulate this function in order to avoid it becomes source of decompensation.

It is important to emphasize how this group intervention, as well as those described above, do not have a strictly therapeutic value.

To summarize the objectives of this intervention for the patients are:

. Help them to see the hospitalization, although initially experienced as traumatic, arbitrary and unfair or empty or boring, like a moment of reflection and deepening of their view of themselves and of the world.

. Provide them information about the disease in a dimensional way, this in order to "normalize" their experience.

. Help them to give an explanation of the nature of psychotic disorders based on the stress-vulnerability model, which reduces any feelings of guilt and shame.

. Help them to become more aware of their symptoms and problems associated with the onset of the crisis.

. Teach them to recognize the early signs of crisis and increase the management capacity of the current crisis, in order to decrease the relapses.

. Facilitate the implementation of coping strategies, to improve self-control, sense of efficacy and, thus, self-esteem.

. Increase the approval to drug therapy, both in and outside the ward.

. Lead them to have a good mental representation of the professionals who have led the group and even some "colleagues" patients, so that their admission may serve as a support and as a guide in the initial moments of crisis.

. Improve their ability to interact with the environment and reduce isolation.

The goal of the service and efficacy indicators are:
. Increased involvement and job satisfaction for the operators with reduction of the burn-out phenomenon.

. Improvement of the ward.

. Improved patient satisfaction.

. Facilitate the collection of information on the mental state of the patients and on the effects of the drug therapy with constant monitoring of the latter and its effectiveness or possible modification. What is observed in the group task is shared at the clinical meeting and enriches the discussion on the treatment plan for each patient.

. Decrease in the number of aggressive behaviors in the ward.

. Decrease of the readmissions in S.P.D.C. and in particular of readmissions in T.S.O.

Numerous researches have demonstrated that the cognitive-behavioral intervention for the most acute patients can be effective even if applied in group (Bazzoni et al., 2001; Drury, 1999; Kanas, 1991; Wykes et al., 1999).

Over the years there were some limitations of this type of intervention related to the structure of the intervention itself, but also to the context of application and the growing shortage of professional resources.

The problems detected were the following:

1) each patient participates from 2 to 5 meetings, so it is possible that he doesn’t complete the sequence of the modules (groups, until a few years ago were made from Monday to Friday, at present, instead, are made twice a week)

2) the short hospitalizations and poor connection to the CSM do not allow, at times, a continuation of the work started in the groups

3) the difficulty in evaluating the outcome of the intervention given the multiplicity of variables competing to determinate it.

**The operators of the SPDC as a group of work**

Thinking also to operators as a group, we made a study titled "Research on local culture" with the colleagues of Clinical Psychology Department, directed by the Prof. Carli, on behalf of the SPDC coordination of Rome and Lazio. The research was carried out from October 2008 to November 2009.
The Local Culture is a model to detect and analyze the social relations within the psychoanalytic theory of emotions. For Local Culture we mean the emotional collusive symbolization of specific "objects" of reality, by persons who share a specific context.

The aim of this research was to evaluate the representation of the SPDC by the people who work within it, and therefore, detect the characteristics of the operators as a group that shares the work context. Working in a group with patients without questioning the size of their group, that of the operators, risks to be a blind work (as if we works only on the transference without care of the countertransference). The group dimension cannot cross only the therapeutic intervention, but must be a method through which analyze and intervene also on the group of operators. Therefore, encourage the group experiences with patients within a specific SPDC must correspond to encourage experiences of analysis and study of the group of operators.

Other goals of the research were to define the change in SPDC, its evolution, its function, job satisfaction and the relationships between the different components of the ward.

The study involved all the SPDC of Lazio, with the self-administered questionnaires that were subsequently processed. The data obtained were analyzed using the factor analysis and have been highlighted 4 cluster. The set of the four local cultures showed 2 majority areas of acceptance, enhancement of service, satisfaction with the work done, and 2 minority areas characterized by anomie and strong devaluation. In summary, we have seen that there was a majority culture of job satisfaction, based on the teamwork, and that it was in contrast with a pessimist culture, based on the request of a strong power, which, in some cases, is completely absent. Still, a culture of satisfaction based on efficiency and competence contrasted with a culture of criticism of the leadership and a little confidence in a possible evolution of the current state.

I fear that, if we repeat the study today, the situation would be much worse, considering that, with the repayment plan, Lazio does not assume more personal for years.

**Conclusions**

We tried to make a contribution that told with directness and linearity, hence the idea to use the transcription of a lesson to young students—the creation of a group and the utility of this mode of action as well as some limitations, in a hospital setting represented by the Psychiatric Service of Diagnosis and Treatment. A context of psychiatry that often imposes itself on the ward's routine and on its activities.

Yet, over the years, we have seen how to create and maintain group interventions along with working in teams represent an effective way to deal with the psychiatric emergency that, often, threatens to overwhelm if there isn’t a structured clinical practice and flexible at the same time. Mental illness and the crisis impose man things both to patients and operators and then it is necessary to offer the tenacity of a space where, as sung by Ivano Fossati <<there is a waiting time as I said/something good
that will come/an instant photographed, painted, marked/there is a dreamed time that we must dream>>>: the group offers very much both to operators and patients this time, a time in which go beyond the “lira” (the portion of land between two furrow) is less frightening.

Notes
1) Recovery from mental illness: term coined by the American psychiatrist Anthony in 1993. The recovery is described such as “the only process, deeply personal, of change of one’s own attitudes, values, feelings, objectives, ability and/or roles”. It represents a way to live a satisfactory life, full of hope and starting points, although with the restrictions caused by illness. The recovery involves the development of new meanings and aims of one’s own life, beyond the catastrophic effects of mental illness.”

2) COMT catechol-o-methyltransferase: enzymes that degrade catecholamines such as dopamine, epinephrine and norepinephrine.

3) With this term we refer to all social and emotional skills defined such as the ability to express both positive and negative feelings in the interpersonal context without determining a consequent loss of social reinforcement; such as the ability to produce and coordinate answers and verbal behaviours which are inappropriate inside an interpersonal context, about which it is necessary doing a suitable evaluation and being flexible to formulate or not the respect of social rules and roles (Bellack et al., 1997).

4) Methylation: chemical reaction denotes the addition of a methyl group producing chain reactions.

5) Acetylation: describes a reaction that introduces an acetyl functional group into a chemical compound; it’s instrumental for biosynthesis of the acetylcholine.

References


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