

Accepting death anxiety and agliophobia and their emotional transformation in a Laboratory Group

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Abstract

A group of psychologists and psychotherapists involved in different health care services for people with severe, lethal or deeply disabling somatic illnesses discuss the difficulty of their job when tackling the pain of the limit, the loss, death and emotional resonance it evokes.

The identification with terminal or severely injured patients is a difficult process: it sometimes leads to a defensive distancing, in other cases it is so intrusive that it hinders the distancing, which is necessary to develop a proper therapeutic relationship.

Other difficulties of the therapist job in this specific field are linked to the uncertainty of time perspective and to the possible setting variation, which is usually the patient's house.

The authors built a supervision group with an external health care professional and they were conscious that this emotional burden can hinder the therapeutic relationship and leave a sense of heaviness and helplessness in the psychologist's mind. Over the years the meetings transformed from a case supervision to an "emotional laboratory", where the focus was put on the therapist who told about his/her life experiences and his suffering/ pain in the relationship with these patients. The person who brought up the "case" felt that his/her "own" pain was shared, together with their patient's one. When the therapist experimented the freedom of expressing his/her emotions, which were combined with the other participants' ones in a new many-voiced storytelling, the impotence, destructiveness and death became thinkable and much lighter.

The role of the group as a mental container, which was enabled through a climate of confidence in other people and in the external health care professional, gave a new boost to the thought and restored the hope, though limited and realist, of being helpful for the Other.

Key words: pain think-ability, identification, death, group, emotional laboratory

Introduction

The supervision experience carried out between 2011 and 2016 will be presented in this paper. A six-year old experience, which was born to be a help for therapists who experience heavy emotional loads in the encounter with death, the grieving or severe illnesses.

When death is sought and when, on the contrary, a severe illness and the loss are denied or refused, a psychologist faces extreme and special conditions. He/she feels emotionally close to the patient, with whom he/she shares the particular and sometimes rare existential drama, but also with his/her previously shut down emotional blocks, and he/she may take the risk to feel less confident in the transformational and freeing action of the therapeutic process. The discussion of clinical cases transforms the work experience of each psychologist in a group laboratory where everyone can achieve a joined-up thinking, thus allowing the different life experiences to be highlighted and shared, and at the same time to underline the patient's real evolutionary possibilities.

This group, which we called "emotional laboratory", was basically born from the necessity to create a comparator group on the psychotherapist's emotional themes when managing clinical cases such as death and severe disability due to traumas or physical illnesses. The group was thought to counter the psychic overload, which, most of all in severe situations, may lead the therapist to burnout, thus reducing his/her ability to properly fulfill his/her duty. The basic need was to find a place where all the therapists involved could have shared their emotions.

The laboratory had the same features of a training group, regarding the gaining of new competences, most of all of an emotional kind. The fact of taking into account the close link between body and mind, together with the work to increase sensibility and the comprehension of emotional aspects, may be comparable to Balint groups' objectives. The pattern and method used were the ones of clinical supervision, but the focus was set on the therapist, and not on the patient. In some cases, the patient had already died or it was no more followed up by the therapist, but he/she felt the need to process his/her own life experience.

Facing death and limits

Terminal patients or patients with a severe disability due to traumas or illnesses are people who are facing a difficult human experience. Each of them tackles it according to his/her own needs and his/her character.

Elias (2011) underlines that in the contemporary world there is a trend to individualisation which "*boosts individual immortality fantasies*"; a trend to isolation spreaded out making it difficult to comfort a patient by showing him/her affection or tenderness, to speak spontaneously and sometimes even considered negative or inappropriate; also patients are tangled up in this emotional isolation and thus cannot share their sufferings.

Most terminal patients and with severe acquired pathologies, make up <<*subjective or environmental resources which allow them to find a personal solution, while others are sustained by a faith or an ideology*>> (Zapparoli, 1997), others may identify a life purpose (waiting for the birth of a nephew/niece, his/her daughter's wedding...) which helps them to face the anxiety evoked by their imminent death or their illness. Certain cases need the support of specialists, in order to tackle death

anxiety or the anxiety connected to their substantial life changes. Our action as psychotherapists is addressed to those who cannot draw on sufficient personal resources and our task is to help them not to live in an anxiety emotional condition, to develop a protection such as an illusion which can protect them from the fear caused by the impossibility to heal. A particular situation is shaped: the consciousness of being close to death and the illusion of healing live together in the patient's mind. (Zapparoli, 1997).

In 1969, Elizabeth Kübler-Ross, while working with terminal patients, came up with a pattern in which five phases were identified during the approach to death: denial, anger, bargaining, depression, acceptance. In practice we noticed that not all of them have been gone through or overcome. Most times, the various phases we mentioned before are interpenetrating or live together, thus creating a conflict.

Just occasionally the interviews with terminal patients are about fears, anguish or more specifically death anxiety. Much more often, these emotions are projected on practical problems which may seem unsolvable and of which the patient doesn't know who to talk about with. In such situations, talking to a psychologist is the most suitable choice, compared to a GP or a nurse, who deal with the body.

As far as severe disabilities is concerned, instead, the most common reason of psychological support is linked to the consciousness of body limits after the illness, while the practical and adapting aspects are often denied, most of all during the first phase. In this case it is generally the institution which delegates the reception of emotional instances to the psychological field.

In any case, we must give up the thought of being able to "cure" the death and severe disabilities, and to do so we have to be able to tolerate the feeling of helplessness, but also we have to build around the patient a quiet emotional environment, developing the most powerful level of communication. The therapist role is to understand which emotions may hinder this process.

Dino was 49 years old when he was sent to psychological health service: his was an existence marked by precariousness, loneliness and carelessness. The community which had welcomed him for social issues and alcohol addiction advised him turning to a psychologist. There are several reasons why he was sent: Dino is a different kind of patient, he was not an alcoholic, he was hindering the health care professionals who did not know how to manage them and he was diagnosed with a genetic chronic degenerative and disabling disease. The discovery of the disease created an unsustainable anguish in the health care professionals. The diagnosis determined a divide between before and after and, although Dino was hardly manageable as a psychiatric patient, after the diagnosis the death anxiety overwhelmed the health care professionals, making them feel deprived of all the means to accompany him along the road which gradually leads to the end of life.

Dino was introduced to the emotional laboratory group because the same difficulties reported by the community health care professionals are experienced by the therapist; this was the right occasion to reflect upon and deepen the similarities and peculiarities of the taking over of severe psychic, invalidated, terminal or disabled patients.

Dino arouses feelings of transfert, tenderness, compassion and nurture, similar to maternage. Also the therapist feels that Dino covered her with many expectancies, which lead her to take full care of him and feels the burden of loneliness when managing Dino's multiple contradictions: confidence and deception, cure and carelessness, omnipotence and impotence, sympathy and distance. Dino is a patient who raises anger and frustration feelings which lead health care professionals, his relatives and friends to keep him distant, until they abandon him and lose hope. The comparison inside the laboratory allows the therapist to express her own emotions and to feel recognized and legitimated in expressing the most negative emotions which counter with the desire to help the patient. Dino, discharged from the community and accommodated in a big flat thanks to the engagement of the Community/Social Service, uses his bedroom like a dump, collecting the garbage over the years. This is an event which undermines the whole network: the case worker, home based health care and the therapist herself, feel as if he makes fun of them, the support threatens him to abandon him. During the discussion of the group laboratory his bedroom becomes the metaphor of Dino's self, of his sick genes, which represent the rubbish his mother transmitted him during his conception.

By being by his side, watching his carelessness and dissipation, most people may not want to change him and let him live his last years the way he always did: every person involved can play his/her role and nothing more, so that they can overcome the omnipotence/impotence which was imprisoning them all.

The fact of having accepted the therapist's emotions made the access to a second development phase easier, which helped to find new vital meanings in the therapeutic process.

The therapist, the patient and his/her relatives

The goal we set with these kind of patients is that of making them be able to live a more rewarding life right away and to safeguard their presence of mind (Gawande, 2016). The most common problems are: hopelessness linked to the dependence on others for every small necessity and the desire to resolve the differences, being surrounded by smooth relationships and a welcoming emotional setting.

As far as terminal patients is concerned, there are several experiences about patients who tell us both about their funeral party organization, and, at the same time, about their future holiday plans: the consciousness of being close to death, together with the illusion of being able to defeat it live together in the same illusory / delusional / unrealistic area (Zapparoli, 1997) which substitutes the unacceptable and unthinkable

reality of death. It is a partial area which doesn't lose touch with the reality of death, but, at the same time, it prevents people from going mad about the consciousness of their imminent end of life. The therapist may seek to develop this illusory area using his/ her unconscious, for example through the messages that the dreams can reveal and which constitute creative and vital parts to be put in place in order to face the awareness of death. Racamier (2010) calls ambiguity the coexistence of two opposite realities and talks about life ambiguity referring directly to death.

Similarly, those people who have to reorganize his/her sense of self and his/her body-image have to face the illusion of a complete healing on the one hand, and, on the other hand, the frustration set by their limits. This ambivalence results in imbalances in the patient and his/her relatives sometimes leading them to situations of conflict which raise the level of suffering.

The greatest difficulty for those who accompany terminal patients is to understand the most suitable way for each person to accept death. It is clear that the role of health palliative care professionals is complex, demanding, and very often catches them unprepared. The role the terminal patient gives us is that of being an intermediary between his/her life and death, his/her future, and between him/her and the unknown. (Zapparoli, 1997). Deciding what, when, how much to tell, depends on the consciousness the therapist has about his/her patient, and on their emotional relationship.

The patient's family is often the environment in which the cures for a terminal or severely ill patient takes place. When the patient's house coincides with the care environment, the type of care is deeply determined by the nature of the familial bond and by the life experiences of each person regarding illnesses and the end-of-life.

At these critical moments, sometimes traumatic, the familial bonds make the thread of the relationship between the patient and health care professionals and show up either as a resource or a problem. Approaching a relative who takes care of the patient is regarded as elective surgery (Giardini et al., 2008). It has frequently been confirmed that the caregiver has to engage in the <<*anticipated grieving process*>> (Giardini et al., 2008).

The patient's relatives are physically and mentally tired and this is linked to the continuous body cure, mostly focused on the body. The continuous home care with health care professionals who are at the patient's home every day interrupts the family privacy and transforms the physical environment, life rhythms and the family atmosphere. The fact that the patient is dependent on physical treatments obliges his/her family members to radically change the means by which the affective bond is conveyed.

Very often the patient's relatives don't even accept the idea of his/her terminal disease: it sometimes happens that they ask for a suspension of sleeping pills and tranquilizers in order to see him/her responsive and "alive".

The relatives may insist on obtaining a psychological support because the patient is a close person, doesn't say how he/she feels, without even noticing the objective

difficulty breathing which doesn't allow the patients to talk. Sometimes they even forget that the patient has always been of very few words throughout his/her life.

In case of severe disability we can see relatives who continuously insist on asking about reducing the patient's "depressed state", without taking into account the patient's reaction formation linked to this attitude, thus confusing sadness and the pain for the loss with depression. In other cases there is a request to intensify the rehabilitation. People who ask for it may think that a bigger engagement corresponds to a better situation. The patient and the health institution are therefore accused of not being committed enough. In the end, relatives may ask lots of professional and expert consultations to save the patient.

All these questions make us think about the difficulties the relatives project on the patient and on health care institutions. In these cases the therapist role is that of containing their anguishes on the one hand, and on the other hand he/she has to give the health care professionals a correct reading of these dynamics.

According to a research carried out by Geode Group (Azzetta, 2013) the psychologist has to know how to *<<frame the relational and familiar story of the illness, in order to know how to describe the way the family integrated the illness with social life; this is made to build the meanings of the family's story before and after the prognosis of the incurable illness>>*.

Assisting a terminally ill relative is tough: there may be time-honored grievances, long-lasting, guilty consciences and very often the patient's character is difficult to manage.

The people involved in this process have to start a difficult process towards the limit acceptance. This is made by a lot of meetings in which the therapists absorb anger, pain, frustration, anguish and fear.

The patient's relative is obliged, in spite of him/herself to enter a crisis process (Racamier 2010) and he/she has to undertake a personal processing path. When the patient's relatives meet the health care professionals they feel the need to protect their own affective role, their investments and belongings. It is a personal journey which, most of all when death is close, may lead to an evolution of the bond, so that it will be kept when the physical, actualized and present relationship dies. One person's death does not coincide with the end of the relationship for the survivor, but must have its own evolution (Drigo, 2012). This is a particularly complex process and sometimes it is not applicable when family relations are full of conflicts, misunderstandings and missed compensations. Suffering becomes the ground for closed attitudes, conflicts, wrong separations.

Pietro is a 60 year old terminal patient because of metastasis. He lives at his elder sister's place and she lovingly takes care of him. He doesn't ask anything to other relatives such as his ex-wife and his son who make their presence felt only to the sister. Pietro is described from palliative health care professionals as a closed person, who is silently suffering, though always kind. He decided how to manage

the proprietary aspects and to spend his last at her sister's house together with her and her husband.

The family history reveals weak parents. The kids were able to face their childhood negative life events thanks to a strong collaboration between siblings and most of all thanks to the elder sister's help, who served as a mother. She is the same elder sister who's now, together with her husband, taking care of Pietro and had previously taken care of their ill sister who died because of a disease.

Health care professionals question Pietro's consciousness level and his impenetrable attitude. They have controversial opinions: in particular, the reflection on the caregiver invigorates the debate and does not help to build a shared vision on the relational aspects with the patient and the caregiver. The health care professionals find it difficult to understand why Pietro's sister is uncontrollably willing to stand by him, instead of her husband, who was hospitalized for a short time, too.

The psychologist takes into account the importance of being neutral and finds it difficult to find the right moment to intervene and serve as a confrontation catalyst, at the base of which there is mainly the patient and his relatives' assistance and not the defense of principles or an action based on unconscious emotive issues. The psychologist finds it difficult to manage her personal opinion and her point of view in order to bring out in the health care professionals' mind the recognition of an authentic request from the patient and of the relatives' free will to respond to his needs.

The psychologist takes her own difficulties to manage the bond between the patient and his sister to the "emotional laboratory" and these are shared with health care professionals. The bond between Pietro and his sister is stable over time and will end for sure, though in the uncertainty of the disease evolution.

It emerges that Pietro firmly wants to manage his last days before encountering the death: together with his sister and refusing any other person's help, even the psychologist's one. Understanding the family dynamics is not enough to ease the therapist. It is crucial for her to understand the resonance with her life experiences linked to building bonds, breaking up, and letting go. The emotional laboratory explains the correlations between these themes and the therapist's personal experience about death and also the ethical doubts linked to family relationships. The therapist can therefore be helped to redefine herself and to welcome and sustain with dignity and respect Pietro's and his relatives' choices, without avoiding the support, the thoughtful and competent anticipation of needs, the support measures for the patient and his relatives.

The therapist's emotional burdens: the setting as space and time

When talking about palliative care, the home care is the first obstacle: since we enter other people's house, we have to play by their rules, we are immediately soaked in his/her "privacy", we are unveiled and without any protection; we can see the family

dynamics with no filter, their house is crawling with their personal story. There is not a table nor a uniform to protect us, the length of our conversation and the people who can take part in it is not established by us. It is the patient or, more correctly, his/her state of health to decide. Home therapy is fully immersive and therefore taking action and deciding what to tell and what to do becomes really difficult. Decisions are often taken quickly and the risk is to get emotionally involved and to be carried away by our concern. Instinct and experience are important factors, but if we do not want to be overwhelmed by the strong emotions that are unleashed in this type of therapeutic relationships, we have to be able to develop emotional rather than rational tools through a training job to the capacity for identification and empathy, the ability to recover the distance and the ability to confront ourselves with the theoretical models. Time is another matter: for the sick people, time is fluid. It can be perceived as interminable or very fast in the present as well as in the past. They look back even just a few months and they see themselves healthy, beautiful and smiling... centuries ago! They tell you about the surgical vicissitudes and the treatments... everything seems to have happened in a month, but in reality years have passed. Often, they need to be helped to give sense to the time which is left or to that which has to be lived in a different way. <<*The way we try to pass our time depends on the amount of time we perceive is still have available for us*>> (Gawande, 2016).

For the family members, the sense of time becomes the cure itself: the day is marked by the care to provide to the sick, while for the sick person it means to rediscover or look for new or alternative paths.

For the psychologist, the control over the therapeutic processes is unplanned, the duration of the therapeutic relationship is unpredictable but nevertheless infinitely shorter than that of the normal therapies; on one hand, it is caught between the time of the health interventions and that of the course of the disease, and in the other in the processing time of the patient. Therefore, how do we reduce in a short time the knowledge of the patient and his history, the construction of the alliance and the choice of the goals?

Working in the field of palliative care or with people diagnosed with serious physical deficits, we are frequently beside professionals who mainly see the biological aspect of the patient compared to the biographical one; our role as psychologists is therefore to focus our attention on their history. By telling who they are and who they have been, the patient is able to recall and remember, and therefore to create a link between the past and the present; and, on the other side, the therapist is able to convey to the health care professionals interest in that person and in their peculiarities that make them unique.

The emotional burden of the therapist: identifying and distancing oneself

In his book "The Meaning of Life", Yalom (2016) describes his experience in groups with terminally ill patients and states that helping them to accept and experience their death is a way to give sense to their life/death.

As a human being, each of us faces the theme of sickness and death, but no one ever becomes an expert; there are no answers or knowledge. As psychotherapists alongside people who live the unique experience of their own death, we make a tiring and continuous attempt of imagination to give meaning and words to some specific pains, an attempt in understanding and listening, a sense of impotence and inexperience, but also a concern from which we escape, seeking refuge in everyday life and work. Sometimes when other people die, we feel paradoxically more alive and fortunate, as if the destiny concerns other people but not us, and this feeling can evolve into a sense of satisfaction as well as guilt. It is an experience that forces us to think about death in general, about our death and about the meaning of life.

Adriana, a young woman sent by her physician to the psychologist, brings experienced a great suffering. The experience of death hit her in a sudden and very painful way.

A serious illness contracted during pregnancy forces doctors to an impossible choice: saving the mother's life while risking the life of the fetus. Adriana survives, the child is born and dies a few days later. The mother, in intensive care, can neither see nor greet him, engaged in the struggle to survive. For Adriana, alive in the irremediably sick body, begins a painful path of rebirth, both physical and psychic.

The request for psychological help, prompted by her doctor who healed her body but not her mind, is accompanied by doubts, ambivalences and long silences. The therapist feels weighed down by so much pain, she struggles to find the right words and thoughts to help Adriana. The patient's anger invades the therapist, making it impossible for her to think. And yet Adriana sticks to therapy, feeling it as the only help that prevents her from going crazy.

The anger, loneliness and pain pervade Adriana's family, her husband, who finds himself living again a never-forgotten family mourning, and her firstborn, who is now an only child.

Suddenly, Adriana finds herself in the condition of not being able to care of herself and her loved ones. Always being used to "do" a lot and "think" a little, she finds herself disoriented in front of the continuous recurrence of post-traumatic, phobic and obsessive symptoms. The body prevails, hamstringing the mind.

The discussion in the emotional laboratory brings out the block of the psychic pain in the therapeutic work: the group highlights the resistance to identification that the therapist, woman and mother, opposes in a defensive and unconscious manner. The "primary concern" for Adriana's mental health clashes with the fear of coming into contact with such a great pain.

The sharing of emotions, feelings and experiences in the emotional laboratory group gives voice to feelings of anger, fear, desire to escape, pain, care, allowing the therapist to integrate them within herself. The role of the therapist emerges as a "psychic obstetrician", which can help Adriana to be born again as a person and

which allows her to accept the pain of the labor and of the psychic labor.

The emotional laboratory allows the therapist to experiment and accept to stop and think about the pain and to see it as a possible event. Therefore, the therapist can identify herself with Adriana's pain, accepting it in the mind and emotions, while keeping in mind the differentiation between herself and the patient.

The therapy, stopped in a suspended time, solitary and without thought, resumes to flow with the slowness of the mourning processing, welcoming the pain of Adriana and her family, giving voice and space to the suffering of her husband and the difficult recovery of being parents.

The therapist, symbolically accompanied by the group of the emotional laboratory, does not feel lonely anymore and can activate a shared and welcoming thinking role, which allows the achievement of the therapeutic goals.

This case proves how difficult it is to identify oneself with distressing pains and how one unwittingly escapes from receiving them; in other cases, the identification is such that the therapist is left immobilized, being completely overwhelmed.

The therapist goes to Claudia's bedside, 23 year old, a month after the accident that caused her a serious spinal cord injury resulting in a complete paraplegia. The patient is aware that the outcome of the injury will not allow her to walk, will force her to use specific methods for emptying the bowel and to face the loss of sensitivity from the trunk down. During the first interviews she cries continuously thinking about how her future will be.

It is impossible for the therapist to find any positive aspect of her past to help Claudia to live and react: her story is a dramatic and painful reality. Her father, alcoholic and violent, died a few years earlier due to a severe stroke. After her dad's death, she started working to help her family, leaving the school and finishing her studies only a few years later attending the night school. She has always been in problematic affective relationships with abusive men, developing an addictive behavior towards them. However, the psychologist perceives some resources that are not clearly defined, but that are lively and solid, construed as well-structured skills that Claudia was able to build, despite her difficult life.

In the first period of hospitalization, the therapist's attitude is characterized by a prevalent sense of inability in managing the uncontrollable pain. During one of the first interviews, when the patient faces her concern for her future with anger, fear and bewilderment, the therapist expresses a sense of powerlessness by saying "I'm not worried about her ability to handle the future because I am convinced that she will find her way to face all the difficulties, but I am worried about the pain she feels now and I do not know if she will be able to grieve it".

Even the presence of Claudia's mother who does not seem to understand her daughter's pain and who seems willing to play more a health role than an emotional one, becomes a source of inquietude and oppression for the therapist.

The exchange of views within the laboratory allows a rereading of the dynamics established among the patient, the mother and the therapist, who feels exposed to the solicitations of the psychic suffering. The psychologist tries to perform a role of pain acceptance (Bion, 1972), without being able to count on a functional specificity construed as the ability of the container to accept and tolerate the content. Therefore, he fails to give it back to the patient in a usable way without helping her to think again about her own situation.

Instead, the emotions of anguish felt by the therapist (referable to the identification with those of the patient), find a convenient container in the emotional laboratory. The group allows the therapist to express his own incapacity, allowing him to distance himself to be able to recognize the suffering and the uniqueness of the terrible situation experienced by the patient. The “emotional disengagement” through the group guidance also helps to understand the projections on the mother, initially considered inadequate and impotent towards the pain of her daughter, enhancing the aspects of care and thus helping the patient to shift the attention on the need to accept a body which is perceived in a different way and has to be rediscovered again.

Therefore, the laboratory plays a role of rêverie (or transformation), allowing the therapist to find a welcoming atmosphere in which he can bring his own experiences, increasing mutual trust (Foresti et al., 2011). We believe that one of the most peculiar points of this experience in the emotional laboratory develops around this dimension: an environment which is capable of welcoming and understanding the pain of the therapist.

The ability to identify with one’s own patient is a fundamental element in a psychotherapeutic relationship: it requires a certain personal capacity, acquired from self-knowledge and individual training. Identifying oneself with patients in less serious conditions is easier as they are more similar to us and it is therefore easier to recover the emotional detachment that allows us to be empathetic while avoiding empathizing with the patient. With psychotic patients, instead, the identification is more difficult: Racamier (1982) says that no any psychotic can identify themselves with those who are not able to identify with them first. Therapists of patients in serious conditions know how distressing and confusing the emotional relationship is with those who use the therapist as if there is no distinction between them.

To us, it seems that something similar happens with the patient who faces death or a serious state of disability. The therapist must have an identifying intentionality with the patient related to a situation that could also break into his life through an accident or a degenerative disease, or that will surely happen, like death, for example. Despite the help of a good analytical training to better understand the experiences of the limit, death and psychic suffering, sometimes the anxiety of the therapist is not only in sharing the concern of the patient, but also his own, which comes from imagining himself and his family in a similar situation. While talking about a patient with ALS

(Amyotrophic Lateral Sclerosis), whose body has been progressively blocked, the host felt for a few minutes unable to play her role, to be active in the group, experiencing a kind of paralysis in the body as well as in the voice. We can say that this example of identification is the expression of a psychosomatic anguish to which, fortunately, we are not used and from which we struggle to defend and distance ourselves.

We must be aware that only a partial identification with terminally ill patients is possible: part of our ego must remain free from identification because only in this way can we avoid developing anxiety (Zapparoli, 1997).

Quoting Eissler (1995): *<<If we can feel the approach to death [of the patient] as if it were ours, we can stand as companions of the last part of his journey. To be able to do this we must be convinced that our emotional participation will be only a sense of sadness and pity, very different from the pain and despair felt by the patient's family>>*.

The difficulty of finding a correct distance in identifying with these patients seems to us to be linked to the distressing and regressive level of the non-functioning of the body: the psyche, if it does not take a defensive distance, can become incapable of thinking.

Conclusions

The clinical examples through which we have illustrated the work of the emotional laboratory show clearly how in the encounter with the patient the therapist can experience the burden of anxiety as too strong; in these situations, which take on traumatic characteristics, we need a space for sharing and thinking.

Our group has been creating itself a time and a space in which this concern is faced, stimulated by a specific person/user, but with the desire to understand emotionally how we can experience these extreme pains, which we are not experiencing personally in that moment, but which are part of life.

The reference model resumes up the experience of the group's mind at work, as described by many authors and mentioned in a recent article (Ferruta, 2018). *<<The functioning of the group according to the method of free associations on the clinical material presented [...] allows us to reopen a dimension of think-ability, to go beyond the blind spots that have occluded the communication between therapists and patient and to recreate, through the re-elaboration of the psychoanalyst conductor, a representability of both the psychic status of the case and the therapeutic relationship. At the same time, the new configuration is both a relief as an advancement in understanding and a tool for clinical indication in care. This training and work tool has proved useful to tolerate the pain associated with the treatment of serious patients, to understand the dynamics underway, and to use the emotional experience lived to continue in the care work>>*.

We could say that it is a healthy aspect of narcissism: the confidence of being able to emerge, with the help of others, from a tunnel that seems to have no way out, to find

something that was not yet known, to learn from experience, without resorting to ready-made solutions that turned out to be ineffective. The support of healthy narcissism is particularly important in situations where death and impotence put a strain on the vitality and narcissistic survival forces: this applies to patients, family members as well as health care professionals.

We like to describe each meeting of the emotional laboratory with a metaphor, as a deep dive, difficult or very difficult, in which we have touched real situations, pain, anxiety from which normally the thought defensively escapes. As in diving, you need to rely on someone to guide you and give you the confidence to re-emerge. And it was precisely the sense of lightness of “re-emerging” what we felt after “descending” in a little known and painful environment. Our fear of death and pain has been observed, shared and elaborated: in this way, we avoid being weighed down by it and we are able to distance ourselves enough to work every day alongside people who face this painful reality.

As psychotherapists, we know how anguish needs a container and how the mind of a mother, a therapist, or a group has the capacity to perform this function. Sharing the painful emotion, seeing that other people can understand it and feel it in the same or in another way, is that psychic work of containment and transformation mentioned by Bion (1972).

This mental work group gave the participants the feeling of being humans first of all, and not just therapists; has allowed us to share the limits (the mysteries) of existence and, in particular, the contact with this healthy area of fragility has made it possible for us to feel strong and be aware of the supporting role of other people, of our patients.

We reminded ourselves of an advice that Luigi Pagliarani gave us during a training course for mental health professionals: you have to live the net of the situations, not the gross! This exhortation reminds us that the situations of psychological pain have a precise weight, which is felt and must be sustained by those who deal with it, but which becomes excessive if we add the “unladen weight” of the dynamics that develop themselves according to the peculiarities of the patient.

Once the pain of impotence and the limit of omnipotence is accepted, the therapist can once again feel confidence in his own skills and hope to find a new way to support patients who experience death and severe disability.

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