Homogeneous time-limited groups and eating disorders

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Abstract

This work describes some hypotheses on the functioning of the homogeneous time-limited group mechanism used in the treatment of eating disorders, led with a psychoanalytic vertex observation. The work is divided into 4 main parts. In the first part, the authors describe the meaning of *homogeneous group* and its characteristics particularly in terms of specific therapeutic elements and group functioning. In the second part, an analysis of the homogeneous group within the treatment of eating disorders is carried on.
In the third part of the work, *Time-limited group psychotherapies* are presented, being these characterized from a *prearrangement* of the term; concepts which appear specific of time-limited group, such us the one of *Treatment Episode*, time-limited group psychotherapy main therapeutic factors and the peculiarity of management are therefore discussed.
Finally, the authors describe their clinical experience with an homogeneous time-limited group for patients affected from eating disorders. The life of their group and the principal themes the group has worked on during a period of nine months are narrated using *the dream* as a privileged vertex of group process observation.

Keywords: homogeneous group, group psychotherapy, time-limited psychotherapy, eating disorder

Introduction

This study describes some hypotheses on the functioning of the homogeneous time-limited group mechanism used in the treatment of eating disorders, led with a psychoanalytic vertex observation.
In accordance with Corbella (2008), we claim that the homogeneous group, compared to the 'mixed' one, favours sharing processes while resisting individuation ones. We think that, thanks to the predetermination of the temporal dimension, the homogeneous group of patients with eating disorders rapidly enables the ability to bring to light lethargized and unconscious elements. Such work focuses on the attribution of meaning to these elements. It allows to create a work culture *on* and *with* emotions from the initial sessions, enabling the ability to tolerate and mentalize them[1]. Quoting Corbella (2008), «the important introduction of the determined time variable, implies the processing of separation, which stimulates the movement

towards individuation. This inevitably reduces the possibility of stasis, which can sometimes be defensive in relation to change, which characterizes the area of fusionality typical of the homogeneous group». This kind of experience can begin to establish some trust in the group experience and in the psychoanalytic vertex of observation, which can later on facilitate the beginning of 'open-ended' analytical work (ibidem).
We structured our study in paragraphs which will guide the reader through the specific aspects of the debating point:

- What we mean by "homogeneous group", and what the specific therapeutic elements characterizing its functioning are;
- The homogeneous group within the treatment of eating disorders;
- Time-limited group psychotherapy;
- Description of our clinical experience.

The homogeneous group

The *Homogeneous Group* is a specific type of therapeutic group, characterized by the presence of people who share the same symptom, diagnosis or typology of problem. Hence, homogeneity is a basic characteristic of this kind of therapeutic experience. However, we must not forget the impossibility, widely discussed in literature, of making a clear distinction between the mechanisms of the homogeneous group and the classic one. The homogeneous group can go through certain phases of the heterogeneous group and vice versa (Vasta, 2004). Thus, homogeneity is a means of selection for the group, keeping in mind that «to suffer similar symptoms or behaviours, does not necessarily mean to be similar at deeper and unconscious levels» (Hinshelwood, in Vasta, 2004). Kibel (in Vasta, 2004) claims that «a therapeutic group can be called homogeneous if it has one or more precise objectives, aims or functions», emphasizing that experience sharing, handled in the right way, can have a therapeutic function and promote the discovery of the Self. This is connected to the function that homogeneity can have in a *prearranged* group (Bion, 1961) with a set duration, in establishing a series of common elements to facilitate the process of healing. The presence of people with similar issues, makes people less reluctant to establish relationships. The possibility to share experiences and pain with those who can understand it, allows people to break the circle of solitude, and to start re-processing a personal space in which one can have an authentic relationship with oneself (Vasta, Caputo 2004). As Costantini and Sparvoli claim, «the advantage of homogeneity consists in enabling a more rapid cohesion and support between the members, a higher rate of attendance, a less conflictual environment, and a faster passage through the initial stages of the group. This leaves more time to be spent on the middle stages, working on shared problems. All this would have positive consequences on faster healing» (Costantini & Sparvoli, 2000).

While struggling to individuate the specific functions of homogeneous groups, Friedman (in Vasta, 2004) found three peculiarities:

1) «The possibility to somehow reassure the participants on their fear to begin, to belong and to participate to the group»
2) «The protection from the anxiety deriving from discussing topics such as inclusion, loss of control and intimacy»
3) «The hope to learn from those who share the same issues and grief»

To these, we can add «the feelings of immediate and deep sharing that come from the knowledge of shared experiences», as well as the fact that «people are not afraid to be judged or rejected because of their pathology». The latter is a key element in the establishment of the group and in the access to a therapeutic experience (we should not forget the great fear of being judged which characterizes patients suffering from eating disorders – Crane et al. 2007). Homogeneity also enriches the group with other specific functions, like the possibility to act as a *specialized container* or *mediator* (Marinelli, 2004b). The group behaves as a specialized container when it activates a transformative change function (like between mother and child). This is due to both the relationship of mutuality it can offer (mutual homogeneity brings to life a pathology that before the *pre-conception* of the group could be interpreted as secret or dubious), and the ability to bring to the surface the fantasies of indistinction connected to the unifying element (Corbella et al., 2004). As for the *mediation* function, it is the ability to facilitate the emergence of primary elements of the group mental state, which consequently become part of the group work.
On one hand, homogeneity is at the basis of the *mirroring process*[2], and it enables the emergence of three different functions in the group field: *commuting, resonance and effective narration*[3]. On the other hand, it acts as a *contrasting region*[4] for everything that is external, different, missing, and non-homogeneous with what is internal to the group. The presence of common elements, perceived as aggregative, facilitates the shift of the dialogue towards opposite elements, authorizing the first psychic movements (Marinelli, 2004b). Finally, homogeneity has an affective function. The existence of the group and of a common problem, promotes what «is regarded as special and able to provide a special unity between its initiators» (Marinelli, 2004b), that we could define as a special sense of belonging.

Homogeneous group and eating disorders: the group as container/body

Because of its above mentioned therapeutic functions, the homogeneous group is particularly indicated in all those psychopathological cases characterized by the fragility of the Self, low self-esteem, interpersonal relationship problems, and social withdrawal. In literature, these aspect are described as typical of those who suffer from eating disorders[5]: «mono-symptomaticity [...] helps people to come out of a situation of alienating and distressing loneliness, to stop feeling like monsters [...]. If

at the beginning of the group its participants recognize themselves because of their symptoms, it is thanks to therapy and to the group that they will be able to recognize that beyond the symptom there is a unique identity which needs to express itself, without resorting to expedients. The group space entails the possibility to process personal space, as opposed to what could happen in a dual setting, in which one could feel oppressed by the therapist's role, perceived as the parental role» (Vasta & Caputo, 2004).
In reference to the hypothesis that an inadequate integration of mind and body could be at the basis of eating disorders, group psychotherapy seems to be a good approach to work on the process of re-integration, where, as Marinelli claims (2004a), «the group regarded as a body (Anzieu, 1976), as an organism capable of corporeal experience and evolving capacity of thought (Bion, 1961), puts the anorexic patient right in the centre of his or her denied half *(the body). The group hence relates to what caused its denial and rejection*».

The position of the leader in a homogeneous group of patients with eating disorders: the anorexic basic assumption and the inclusion of the analyst in the group

In her book *Il gruppo e l'Anoressia* (*The group and Anorexia*), Marinelli indicates a theoretical clinical model which helps understanding why the group setting is particularly indicated to treat patients suffering from anorexia and bulimia.
The position taken by the group leader, is a specific characteristic of the group mechanism. This is connected to Bion's idea, according to which the group analyst should find a way to tolerate the elements coming from the group field, without reacting with an immediate interpretation or answer which saturates the field. In fact, we think that the leader has to ensure the non-saturation of the group field, hence avoiding any kind of collusion with the 'lack of thinkability' which is one of the typical elements of the state of mind of those who suffer from an eating disorder. Therefore, to tolerate a germinative emptiness is in contrast with the emptiness that prevents human experience.
Such depriving emptiness introduces us to what Marinelli hypothesises as a possible specific and peculiar element of the monosymptomatic group field for people suffering from eating disorders, which she calls group in an anorexic and bulimic basic assumption: «a possible model for the analyst could consist in being and feeling 'included'. He could work from a twofold vertex, according to a conception of space of the group which includes the inner-outer confusion, while binocularly seeing the time urgency: compressed and loose, motionless and endless, whole and fragmented and so on, which considers these elements able to penetrate its whole experience.»
The anorexic and bulimic basic assumption, comes to life thanks to the possibility the group has to develop a culture and a mentality connected to its own archaic fantasies,

related to the primitive eating model (ingestion-expulsion, incorporation-disappearance, dismembering-rebirth).
Marinelli explains the *included analyst* concept referring to the wish of the group (which is manifest from the very first sessions) for the analyst to become «a source of specialized truth, containing treatment, space, time, words and generation, provided that these elements are regarded as already existing in the group. It would have sufficed to access them and take full possession of them. Alternatively, to the contrary, those elements were perceived as trapped in a denied space, inaccessible and idealized, which could have never been embraced or included». When the anorexic patient shows withdrawal and narcissistic retreat, space, time and the internal representation of the Other are denied. In these situations, the group, in order to come back to life, asks the other-analyst to be included, in order «to redeem an extremely powerful fantasy of being and, at the same time, of imagining the opposite».
In another study, Girelli & Vasta (2010) further analysed some aspects of the mental discipline followed by the leader within the group work, emphasizing the ability of not taking into account individual and group psychic movements within situations that have a pre-established meaning.
However, to avoid saturating the field does not mean to take a motionless immutability stand on the bulimic anorexic emptiness. In fact, the leader, has to keep in mind that eating homogeneity is a means to set group work in motion in situations in which the shift to higher differentiation stages is an important development within the group process. This can happen through what Kaës (1976) calls *isomorphic-homomorphic oscillations*. He refers to that oscillating movement which is directed to turn that situation in which the group is pervaded with a fusionality state that sees in eating disorders the origin and the maintenance factor, into a situation in which it is possible to elaborate the differences and proceed towards a process of individuation.

The time-limited group

By 'time-limited group', we mean group psychotherapy in which the end of the treatment and the number of sessions (usually between 12 and 70) are prearranged at the beginning of the therapy. The whole treatment period usually varies between a few months to two years (Costantini & Sparvoli, 2000). The prearrangement of the end of the therapy, differentiates time-limited therapies from short-term therapies. Short term therapy has a shorter duration (less than 25 sessions or less than six months), and it aims at having specific effects in the shortest possible time (Budman et al., 1994; Mann, 1973). This pre-established time limit, a key characteristic of time-limited group therapy, seems to «favour a higher *density* of the work time and a faster application of what people learned in the group to the outside everyday environment» (Costantini & Sparvoli, 2000). It is as if the deliberate use of the

temporal dimension, that the leader has to constantly remind the group of, became a tool to access and concentrate the therapeutic process.
Time-limited group therapies can be divided in four main categories: Social skills groups, Cognitive-behavioural groups, Interpersonal supportive groups, and Interpersonal exploration groups, characterized by an interpersonal and psychodynamic orientation, which can facilitate active and introspective work among the participants, with the aim to reduce invalidating symptoms and to achieve a change in their personality and modality of interaction (Yalom, 1997).
Apart from being in agreement with the national health service requirements, (Marinelli, 2004b), time-limited group psychotherapy is indicated as a *treatment episode* (Budman & Gurman, 1988) within a wider and more global healing process, which is often necessary for chronic psychiatric pathologies (Costantini & Sparvoli, 2000). Among the basic strategies recommended by MacKenzie (1997), in time-limited therapies patients are selected very accurately and the direction style is active. The aim is to achieve a therapeutic environment that includes a personalized space for individual patients connected to each other, as well as a mobilization of resources inside and outside the setting, which can help consolidate positive changes. This would seem to contradict our previous statement. Hence, we would like to clarify that we are discussing the position and the mental state of the leader, which characterizes his educational background and his present professional choices. The therapist should be able to activate such position and mental state in specific moments of the group existence. Under certain circumstances, this does not exclude the possibility that the leader might use a more immediate communication style.
Costantini and Sparvoli (2000), claim that the most important Therapeutic Factors in time-limited group therapy are the selection of the patients, pre-group preparation, the individuation of a therapy focus, the composition of the group, the importance of the phase of establishment of the group, the role of the leader, and the attitude towards time.
Therefore, the accuracy in the selection of the group participants is very important. MacKenzie (1990) and Piper and Perrault (1989) state some specific contraindications of group therapy: the clear refusal to participate to group therapy; the presence of conditions like active phase psychosis (with patients showing psychomotor agitation or clearly needing a more indicated low-stimulation environment), paranoia or extremely severe depression (which would imply too much work for the group). Furthermore, a time-limited exploration group is not indicated for patients lacking insight, communicative skills and interpersonal sensitivity. It is also not advisable for the ones who would be penalized by an active therapeutic approach, or for those who cannot guarantee a regular attendance to the meetings, which would therefore compromise the development of group cohesion.
The management of a homogeneous time-limited group, requires the leader to engage in a more intense and specialized activity than in an open-ended group. This facilitates the establishment of a work space from the first few sessions. While

homogeneity facilitates the entrance in the group and the fusion and sharing movements within the group, the temporal dimension helps to emerge from the initial fusionality state. These temporal constraints, accelerate the group movements toward the processing of separation and individuation, whereas to linger over this stage would be counterproductive for the recovery process (Corbella, 2004). The prearrangement of the end of the treatment, promotes an *intentional vector*[6], which aims at achieving an early mobilization of therapeutic processes (Fasolo, 1992). It also gives the group the opportunity to immediately deal with time, an important variable which compels the group to face the expectation and the future: «The awareness of the limit […] entails the possibility to explore, at different levels, the temporal dimension in all its different aspects-- from its archaic origins to its symbolic meaning -- respecting individual differences among participants. It also gives the opportunity to deal with separation, individuation, solitude and death» (Corbella 2004).
Together with the need of a more active management, time-limited groups are characterized by the presence of a therapy focus, which will vary depending on the kind of patients in treatment and on their emerging needs, but also on the institutional environment in which the group takes place. All analytically oriented groups aim at acquiring a mentalization ability[7]. Their objective is to «make the group a meeting place that -- at different levels -- activates or re-activates the ability to think and dream, both of the group and with the group, in every possible way» (Corbella, 2003; 2004).

The clinical experience: the time-limit Homogeneous Group with patients affected from eating disorders[8].

As long as the principal theoretical perspectives have been presented, in the following part of this work we are now going to present our clinical experience, being it based on the mentioned theories.
Our work is based on the hypothesis that the creation of a group begins by means of the *preconception*[9] (Bion 1963) of an adequate mental space for that group and only in a second time it continues through the encounter with the real group (Marinelli, 2004a).
As a result of such an hypothesis, the dialogue among the group therapist[10] and the institutional committee had started a very long time before the first group session. First we started talking about the possibility of realizing a time-limit homogeneous group for people affected from eating disorders[11]; as long as we proceeded in talking about it, we hypothesized about the introduction of a trainees in psychiatry as a silent observer[12], being the latter also involved in the medical and nutritional care of the patients. Such a double role of the observer seemed us useful and precious for two principal reasons: firstly, it would have protected the transition of patients from a medical healthcare toward a psychotherapy; secondly it would have permitted the

realization of a setting where the body/mind integration would "concretely" take place.
The beginning of the group was preceded from four individual meetings with each patient; both the group therapist and the observer took part in it. The meetings realized a first *encounter* space, where each patients' personal affective and relational representations could be hold with the aim of evaluating whether a time-limit homogeneous group could be an appropriate treatment for each one. All patients were suggested to meet us from the same committee and such a process had therefore already realized an initial but partial selection: they all were young women, whose desire for cure had already been verbalized; moreover the majority of them would transit in the group after an individual psychotherapy. Among all patients encountered in the initial evaluation, 7 were selected for the group while 4 were indicated an alternative therapeutic program, which appeared to be more appropriate to their needs[13]. Being the group based on the clinical homogeneity we had to be very careful in excluding these patients whose symptoms normally found in eating disorders were secondary to other severe psychiatric conditions.
A particular effort was put in listening and hold each patients' fantasies and fantastications regarding the group as well as everyone's difficulties in acceding a group therapy; being persons affected from eating disorders characterized from a very fragile self esteem the four meetings appeared to be protective towards the risk of therapy *drop-out*, being it dangerous for the possibility of rising failure and feelings; moreover the meetings would facilitate a faster development of a group cohesion and therefore a more immediate group transition into an interpersonal work (Mac Kenzie, 1990; 1997).

The Group

A 9 person group was therefore born and it included 7 patients, the therapist and the observer. The homogeneity of the group was based on three factors: all participants suffered or had suffered from an eating disorders, they were all females, and their age was among 20 and 35 years. We hypothesized that such an homogeneity, strengthened from the temporal dimension, implicit into a time-limit group therapy, could accelerate the group processes and permit a work focalized on identity themes[14] and on an interpersonal functioning (*focus* of the therapy).

The setting

The sessions, lasting 90 minutes, took place once a week for a period of nine months into a room of the Institution. The group therapy where discussed every fortnight with a group psychoanalyst[15].

Dream as a system of auto-representation

With the aim of describing the group processes and some particular moments of the life of this Group existence, we decided to present here some dreams; as an unconscious reflection of its processes we actually believe *the dream* to be a mean capable of expressing an clarify the group situation (Pines 1999). According to Neri's thought (Neri 2004) there is a set of *Systems of Auto-Representation* and sense determination, also called *Semiosfera*[16], which collaborate in processing both individual and group emotional states. One of the most important systems of Auto-representation is the *dream*; no more considered only as something which should be interpreted, in the group the dream is enriched from the function of expressing what is happening in the analytical situation. The dreams therefore assume a double meaning maintaining at the same time its individual meaning and constituting a group instrument for elaboration; for this reason it is no longer important than the therapist interprets the dream but that he/she uses the dream as a mean to open /bear to elaboration spaces available for the group.

Construction of the Group container

Through narration and discussion of a few dreams, whose narration in the group seemed crucial for the group existence itself, we will now try to enlighten the group course. We will therefore describe the group development from an initial condition of foundation and container construction, being it characterized from confusion and fusion through a more individuated state.

First Dream:

During the third session a patient narrates a dream: *"I was having a Safari in Africa with other persons, I was chased by a savage animal, a beast.. I ran and ran trying to escape.. my legs were harmful.. I woke up terrified and did not remember the final part of the dream, I tried to remember it but I could not".*

The group associates to this dream, whose narration solicits the narration of lost memories, now recovered thanks to the other's listening; a patient says: "before coming to the group I didn't remember my dreams. It now sounds strange to me to remember dreams and I don't either know if I like it or not!". The dreams appear as a representation of a condition regarding the entire group, now feeling attacked from emotions whose arrival stimulates the flight.

At this moment of the group existence, the space allowed for emotions is still a limited one, characterized from a sensorial dimension of the pain (leg harmful); the group is proceeding in the construction of a Container which could be intended also as the necessity of allowing a body capable of transforming sensations into emotions and into cognitions and them all into memories.

Group, body, monstrosity: the group as a system in resonance

The container construction was sided from the group ability to became a *system in resonance risonanza*[17] (Foulkes,1948), characterized from an adequate level of emotional elaboration with participants appearing linked to each other from a strong emotional contact and capable of catch and tolerate their emotions. Through Z.'s dream the theme of feeling monstrous is brought into the group and another crucial theme, that of curing through sorrow immediately follows it.

II dream

Z. was in her house. She noticed a lesion on her back and was certain of having contracted scabies; terrified from the possibility of infecting her son, she decided to medicate her lesion by herself incising the lesion with a needle and medicating it with a specific product. In the dream she obliged her husband to go out at night and buy this product but the product caused an allergic reaction with fever and Z. was therefore obliged to stay in bed and taking antibiotics. Her husband and relatives were very worried and looked after her; she was frightened but at the same time happy for being cared.

In the same session Z. brought into the group her worries about contaminating her five years old son: she fears he could develop an eating disorder; she tells she is terrified to find it out of not being a good mother. The whole group is very familiar with monstrosities Z. talks about ("I thought I had scab and I was horrified from the sensation of having a parasite inside me, terrified of being wrong"). The image of Z. using the needle to cure her lesion by herself lead the group to think about traumatic experiences in their life as well as on the necessity of contacting a traumatic area as a mean to come in contact with the body. Feeling the same corporeal sorrow of the traumatic experience appears as the unique mean for getting back a feeling body. Moreover this narration appears as the expression of the group fantasies on what is now taking place in the group itself: through the narration of this dream and of the autonomous cure of the lesion on the back, the group expresses its difficulties in going on, in trusting each other instead of continuing practicing autonomous therapies (this theme is very well expressed in a session centered on the narration of the difficult relationship of most participants with their sisters). Such difficulties are absolutely normal during the first months of life of a group and in this group in particular since something harming is actually taking place "at the back" of the group: other clinicians from the same institution indicated to L., a participant, to go into a residential centre without discussing such a delicate decision with the group therapist and the observer. L.'s departure takes place after 8 sessions and L. herself communicates it to the group one session before departing: unavoidably it leads into the group anguish, restlessness, rage and sorrow other than nourishing a paranoid condition of alert which made it possible for us to hypothesize that the group is now trying to prepare itself for the incoming Separation due to Christmas holidays.

Tenth Dream:

T. narrates a dream she had the night before meeting the group: *"T.' s mother has died; T. has to look after her father that is now alone (she cooks, she irons, she tidy*

up the house).. she feels bad and disconsolate but despite it she doesn't show it and appears normal as always. She is surprised of noticing her brother bothering about everyday matters as if nothing had changed. In a following imagine, T. bursts into a desperate cry".
After T.'s narration of her dream, J. becomes upset and the group invites her to share what's happening: while crying she narrates about the worst result of a medical visit she had today and brings into the group her worries about dying and her guilty feelings for the way she treated herself; moreover she is now worried about how to report it to her father. Her father does not trust her and thinks she is not able to change anything; he will certainly think she'll unavoidably dye. J. therefore remembers what happened when her mother died. Exactly in the same way described from T. in her dream, J had not been able to show her sorrow and despite feeling it very strong inside she had been all time worried about helping her relatives. She remembers that when her mother was buried, everyone around her were cried while she felt absolutely paralyzed and wondered about what she should have done…she therefore decided to take some flowers and started putting them around her mother's grave in the same way her mother herself had taught her when they went together to the cemetery to visit J.'s grandparents. Everyone around her got surprised from such a behavior and accomplished J for her strength and serenity while she silently suffered all the sorrow she felt inside. She therefore remembers the following period and the different solutions she found to soothe her sorrow: the use of drugs as a mean to appear a normal person, while destroying her body. A group dispositive capable of using T.'s dream to represent what J. is not able to think, has permitted J.'s narration and a consequent general commotion in the group. In the same session the group associates with other dreams where is not another person who dies but the dreamer herself. When an aliveness loosen or forgot reemerges it is followed from the appearance of traumatic elements and death anguishes which appear to deal with the Dead Mother Complex described by A. Green (1983). Almost all patients affected from eating disorders found themselves in coupling the alive/dead pair with the body/mind relationship and the latter appears in this session less split due also to the newborn capability the group has in processing: all patients refer having beneficiated from taking part in fitness activity and these appear strictly connected with the therapeutic project; sports are no more practiced in a compulsive way with the only aim of losing weight but has become part of each patient's individual project in taking care of his body, as if the group was slowly developing an ability in *processing emotions*.

Circularity, transformation, multiplicity

The XIX dream narrated into the group helps the group in continuing processing and allows the group in facing another very important step: sharing a mourning. *"I am inside a room with my boyfriend.. I have a razor in my hand and I start cutting*

myself…it flows plenty of blood but my boyfriend doesn't notice it until when I collapse." The group is invited in sharing everyone's association to the dream and J. start narrating what happened to her the day her mother died: she was playing in her room when she heard a scream coming from her mother's room; she therefore decides to share with the group something she had hid for a long time since she found it impossible and horrifying to talk about that day. Now in the group she can narrate it in details from the scream she heard while playing to the plenty of hours spent sitting up at her body; she can finally share with the group one of the most traumatic moments of her life, which has therefore became a mourning of the group. At the same time, J. used the group as a *mediator* to get through her mourning and gave the group a *mediator* to get over traumas, difficulties and mourning in a different and new way. Moreover, J. has given the group the possibility of going through a separation in a new and not expulsive way, a process which appears necessary for proceeding through the group conclusion and which confirms a new approach the group (now in the XXXIII session) has developed for moving from a generative dimension. The group, now being a container solid and skilled in transformations, has became capable of going through a mourning as well as looking the cut and the blood in T's dream and hearing the scream coming from J's mother. The Group container has developed the father's role which appears protective and indispensable for realizing a transition through adulthood, separation and the close group conclusion[18].

Group Conclusion

Having the peculiarity of being a time-limit group, it was almost unavoidable that getting closer to the conclusion of this experience the group therapeutic process moved on themes regarding loss and separation. In a way that appears as the result of the awareness of the end of the group and of emotions connected with it, the latest sessions became the chance for dealing efficiently with more ancient difficulties.
Both in an implicit and explicit way, the group tackled the mourning expressed in the last dream as well as the fear of being abandoned but has also became capable of creating new projects, whose beginning takes place before something else end. This new ability is well represented from the condition of pregnancy of a patient other than from each patients' ability in putting her effort in a personal therapeutic initiative or in a job project; each person has developed the capability of taking care of someone as the dream J. narrates in the penultimate session expresses: *"I am with a child-* she resembles me when I was a child - *and I have to take her somewhere…there is plenty of difficulties and I have to protect her from it.. there are very narrow streets and dark alleys and I know I have to protect her from different types of danger. Then we meet a group of musicians.. the play an instrument I have never seen before but the music is pleasant and we stop and dance. One of the*

musician to the child and I realize that is both a conchiglia and a watch and it signs 6 pm[19]*".*

Separation and Growth

One of the latest sessions Z. communicates of being pregnant soliciting in the group joy and enthusiasm as if this pregnancy also was the result of both the fecundity and the capability of generating of the group. The image of Z. pregnant surrounded from the other participants appears perfect to represent the condition of the group close to its conclusion with a solid container and committed in going through Separation and towards Individuation other than in facing its fecundity and its transition towards a new phase of growth.
During the last session the patient who had shared her mother's death with the group wears for the first time a ring belonging to her mother, she had never courage to wear before.
Exactly as the imagine of the baby in the mother's womb, the ring appear as another imagine of *Group auto-representation;* the group is now full of relationships, circulation of affectivity and ability to generate, being the latter confirmed from the individual *talk* with each patient. Every participant in fact asked us to have an individual meeting in order to "think" together to her personal therapeutic project. After a lean period of two months the majority of participants will ask us to continue a psychotherapy and, depending on the analysis of each patient's desire for cure, it will be organized in a group or bimodal setting, being this time the group setting not characterized from time-limit.
We close this work with another dream, brought from a patient after the end of the group in a meeting she requested to ask us to continue her therapy in a group: *K. asks to the director of her school (she is now concluding her specialization in fashion designer) to take her in another school where she would like to propose herself as a model. In this school she will ask for having her hair cut from new colleagues she had ever met but she knows that as expert on in it they could find an haircut good for her. She was a bit fearful but at the same time she knew she could trust them.*

Notes

[1] «By mentalization ability, we mean the ability to symbolize, to connect one's problems to thought threads, to create mental structures which are open to new meanings» (Pontalti et al., 2000).
[2] See Lacan, 1949 and Winnicott, 1965.
[3] The term *commuting*, refers to the commuting trains that carry people from one city to another or from the suburbs to the city. Neri (2004) uses it to indicate the «functions involved in the process of moving elements from the individual dimension to the group dimension and vice versa». In order for problems to be properly

processed within group therapy, they have to be dealt with in the group field. This can happen through *commuting*, which includes *effective narration* (intentional and particularly creative), and *trans-personal diffusion*, (non-intentional and unconscious). In a few words, an *effective narration* can put the listener in touch with the emotions, thoughts and feelings in the group field. On the contrary, the *trans-personal diffusion* of mental states is non-intentional: "like a gas, it could pass the barriers set by the 'mental skin' and by the group borders".

[4] The concept of '*contro-campo'* (contrasting region) has been introduced by Marinelli (2004b) to describe one of the functions of homogeneity in the group: «The function of homogeneity acts as a 'contro-campo' to what is external, different, lacking, non-homogeneous with what is internal to the group. This way, the various elements perceived as common or elective, would recall by contrast the opposite elements to converse with them».

[5] See Bruch 1973, 1978, 1988; Curi, Novelli 2004; Marinelli 1996, 1998, 2004a; 2004b, 2008; Novelletto 1993.

[6] In our clinical experience, which we will present later on, this will come into practice through a *here and now* approach, which, thanks to the prearrangement of the end of therapy, aims at emphasizing the intentionality towards the future. This approach promotes an *intentional vector*, which aims at achieving an early mobilization of therapeutic processes.

[7] For more details on "mentalization ability", see note 1.

[8] The clinical experience here described took place into an Eating Disorder Outpatient Service located into the hospital of an Italian University.

[9] We refer to the Bion's theory of Preconception as a psychical condition where a selection of phenomena can be caught other than a mean where contained are suspended into a convivial relation container-contained possible through allowing the doubt. Moreover, in Bion's theory the union of the preconception with the realization gives rise to conception. The application of the Preconception into the Homogeneous Group and into the Institutional Settings is developed from S. Bruni et al. (1999).

[10] Dr.ssa Francesca Natascia Vasta.

[11] The diagnosis were made according to DSM-IV. All patients except one presented a Bulimia Nervosa and three of them had a previous story of Anorexia Nervosa.

[12] Dott. ssa Marta Scoppetta.

[13] See the paragraph on time-limit group in the present work.

[14] Part of psychoanalitycal literature on eating disorders (Bruch 1973, 1978, 1988; Curi Novelli 2004; Marinelli 1996, 1998, 2004; Novelletto 1993) treats eating disorders as a syndrome comparable to an identity deficit with development of a *False Self* (Winnicott,1960) and to the failure of processes integrating developing part of personality. This failure take place during adolescence and can be the consequence of a fragile identity, set up during early infancy as a result of an inadequate affective regulation in the mother-child relationship (Vasta, Girelli et Al. 2008).

[15] Dr.ssa Lilia Baglioni.

[16] Semiosfera is the semeiotical equivalent of the Group unity and of the creation of a shared sensorial and emotional area, the group shared space. It constitutes a very precious element, a sort of compass for the analyst, whose conduction will be oriented from the systems of auto-representation: the analyst will use it to moderate his/her intervention and facilitate the group work, being careful to not overlap auto-representations and group systems but insert it (as missed rings) into the group associative chain (Neri, 2004).

[17] A Group can be considered a System In Resonance when it is capable of processing an emotion and two or more persons are in resonance (emotional contact) on a specific theme or fantasy (Anzieu,1976; Foulkes,1948).

[18] Acquiring the father's role and moving into an oedipal dimension, this group has become capable of facing a phase of the growth which is often altered in person affected from eating disorders: M. Recalcati (1997) states that these persons are characterized from a failure in the mother's role of facilitating individualization and differentiation sided by a failure in the father's role of facilitating a transition from a dyadic relationship Mother-Child to an oedipal triangulation Mother-Father-Child.

[19] 6 pm is also the time of the sessions' conclusion.

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