ARGO Associazione per la Ricerca sul Gruppo Omogeneo
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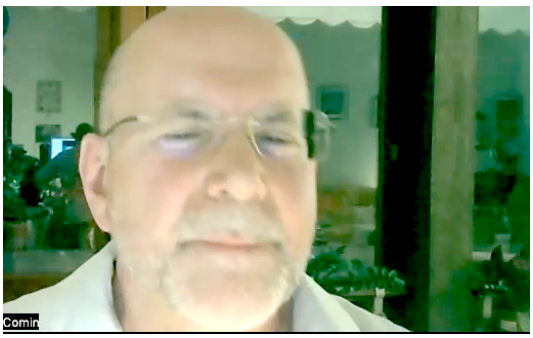
Group psychoanalysis: 50 years of work report



The group in care communities
Interview with Livio Comin

Edited by ***Stefania Marinelli***

Question: I greet you and thank you for accepting this interview, which after all arises from an ancient collaboration of ours, since Florence has, let us say, distinguished itself in the history of the network of ties of the Group Research Centre the "Pollaiolo" in Rome, for having immediately answered the call! and I am pleased to recall with you the experiences of working with groups in the city of Florence and, in particular, in the therapeutic communities where you have extensive experience. So, I ask you some questions that I have partly anticipated. I thank you for agreeing to collaborate with your answers. My first question to you is this: could you say that in Italy group therapy in the institutional context and, in particular, precisely in your your experience in therapeutic communities, has its own history compared to, for example example, to that recognised as the model of the therapeutic community Anglo-Saxon therapeutic community and, if so, could you indicate the main specific qualities of the tradition Italian tradition?

Answer: I thank you Stefania for this opportunity that not only allows us to us to meet again, it also allows me to think back and recall past experiences important for me, as a person as well as a professional and that in remembering make me feel nostalgic for the time in my life that ended two years ago, that is, since retiring, I left the health institution and therefore from the mental health services where I worked for so many years. So, I come to the question. I would like to make it clear that I will say things that are based on a relative point of view, i.e. the fruit of my subjective experience, certainly with constant references to the context in which occurred and to the people and colleagues who were actors in this context. context. The question you propose concerns a comparison between the model, the English experience and our experience. Let me clarify what my experience means by specifying the summit. I have worked with groups with an analytical approach, precisely that of the of the small analytical group and the whole of this work can be summarised in two phases: one, which you also knew directly, centred on groups in the therapeutic communities, especially 'Il Villino' which Gianni Di Norscia had founded, and a second phase, characterised by groups in territorial mental health services in which I worked together with Giuseppe Saraò. The English model, undoubtedly in the psychoanalytic field the main model in Europe and very different for example from the Argentine model, was born as we know already in the 1970s with the work and elaborations of psychoanalysts such as Tom Main, Hinshelwood, Rapaport, Jones and, not least in value, Norton with his experiences at the Henderson Hospital in London. Mentioning a hospital allows me to make a clarification of contextual difference: to a large extent and especially at the beginning the therapeutic communities in England were inside the hospital: in the hospital there was a crisis ward and a therapeutic community ward where the patients who were admitted there did a course of at least six months. In our hospitals there is only the crisis ward, called SPDC (Psychiatric Diagnostic and Treatment Service), and all other facilities (therapeutic communities, family homes, day centres) are in the territory. The founding principle of the English model is group therapy, namely the Foulksian type group therapy. For example, the placement of new patients are decided not by the treatment team, but by the community group, i.e. by the patients together with the operators. Then there is the Crisis Group: for any difficulty, a conflict between people, an anguish disruptive distress of a patient, etc., whether during the day or at night, a crisis group is activated a crisis group, i.e. all the patients and operators present in the community at that moment community come together to analyse and deal with the situation. I am quite familiar with this model because we had an experience organised by Gianni Di Norscia, who invited English colleagues here in Florence who applied their therapeutic community model and for several days we simulated a community experience where they simulated a community

experience where they acted as therapists and a group of us Florentine colleagues played the patients. The idea is that the group instrument is the place where all the situations and emotions that occur in the community and the purpose of the group is to expand and internalise the capacity reflective capacity of the person, of the patient, with the aim of developing thinking thinking people. In England the thing is also particular because the therapeutic communities are grouped in an association that has an agreement with the state, which is however a private association, although in fact supported by state contributions. A very particular model, because these communities host an average of 25 patients, which is not applicable here in Italy due to the Basaglia law, because here the community facilities must keep to around 12 patients, maximum 15, and this for the idea of preventing them from becoming small asylums. There are therefore communities with twenty-five patients for an average treatment period of seven months. In the years when all this started in England, here in Italy the therapeutic communities were those for drug addicts. Mental health services were not not yet organised and equipped to use this tool. Communities for drug addicts were practically born on the 'Man Project', a US model that was improved by CEIS [Italian Solidarity Centre] and where all the activities and the groups themselves that were made - mostly occupational groups, were aimed, to put it schematically, at rehabilitating of ego functions, such as the ability to withstand frustration, to complete a task, etc. complete a task, etc. A clearly different model from the one that later in Italy developed in mental health. As dates I think we can refer to the 1990s, it was in fact in 1998 that the published what for me is the basic text of the Italian psychodynamic conception of the functions of groups in therapeutic communities *La comunità terapeutica* [ed. Cortina Milano, by Ferruta, Pedriali, Vigorelli and Foresti]. The model proposed in this text is also the model I have worked with. What model is this? What is this model based on? It is based on the idea that patients experience a community that is made up of a set of partial objects (their room, their caregiver, etc.) which then have to be integrated into a whole object, an integrated object, the community object. How and where does this integration take place? It takes place in the therapeutic group carried out within the community. So we could say that this model worked, works and is still used today on a conception of care that is mainly based on the cohesion of the self. In short, the therapeutic group thus conceived and used we can understand it as a producer of connective tissue. I use this metaphor: connective tissue, as we know, is not a unique tissue, but is a collection of tissues in our body that have the common characteristic of our body that have the common characteristic of nourishing the tissues of the vital organs, thus enabling the organism to function. This is the summary of my experience.

Question: I would like to thank you very much for the great clarity on such an obvious complexity. I think I also want to pay you a compliment: when you talk about what really interests and excites you, you acquire a clarity that is astonishing clarity. So this description of a social function of the group within the therapeutic community institution emerged very well and I personally liked this metaphor of connective tissue very much, thank you very much. I move on to a second, more specific question about your experience. So, recalling a paper you wrote years ago, you dealt with the difference in group therapy between different settings. There is a classical setting, in which the participants are not in contact with each other outside the group, as is usually participants are advised to do, and to respect the rule of not each other outside the group. And there is instead the treatment setting precisely in the residential therapeutic community, in which the participants are also those who share among themselves, outside the group, a very considerable degree of corporeity, sensoriality, since they have a daily habit of cohabitation and sharing of habits. And this makes a group leader group, such as you have been in the therapeutic communities where you have participated and worked, creates a remarkable specificity. Can you tell us about it? Thank you.

Answer: Gladly! Let me premise that in my experience the intimacy, the field that is formed within a psychotherapeutic group is specifically generated and own of that group regardless of whether its participants share a therapeutic community experience or not. Having specified this, I can tell you that for my personal and professional history in this field, your question leads me back to the second phase of my experience, to the period that lasted until I retired a couple of years ago. During this period I did groups in the territorial mental health service with outpatients, i.e. patients who come to the service, have their psychiatrist and receive individual treatment, thus patients who do not have a relationship with each other beyond the group. I would add that I also happen to do groups privately and this is another level again. In the sense that if you do a group in a service, you are still inside a container. Of course, inside this container you are an analyst therapist so you work with the container of your mind, there is the psychotherapeutic group that you lead and then there is also the team, the working group you are part of. This is a specificity of this context. The purpose of the psychotherapeutic group in this context, bionically speaking, is the classic one: that of developing, through the γ [gamma] function of the group, the α [alpha] function of the individual, i.e. the purpose of developing the capacity for thought, of metabolising difficult, distressing, dissociating psychic elements. Once the purpose has been specified, a methodological question must also be clarified. Of this I will discuss this by referring to my first experience of groups in the public service many years ago. At that time I worked in a SERT, in a service for drug addiction, and with great enthusiasm, because it was the time of training, of

the first experiences. There I started doing a group with patients from the service, with patients of significant severity of drug addiction. It lasted less than a year and I then had to reabsorb patients individually because I had made a mistake: the curiosity of the operators of the team was such that it constantly attacked the intimacy of the group and in the device had not provided a safeguard system, a function of protective membrane. I still remember: we had the group on a Monday afternoon, at 5 p.m. The next morning, when the patients in the group went for their urine collection for routine checks, the nurses would ask: "So? How did the group go last night? What did you manage to report?". Here, in this device lacked the protection of the intimacy of the session, that is, it lacked the guarantors of the setting with respect to metasetting, with respect to the service. Subsequently, in setting up psychotherapeutic groups in mental health services mental health services, with other colleagues, I particularly remember Giuseppe Saraò and Giacomo Tessari, we paid a lot of attention in setting up guarantors of the group setting, especially through service workers who, by participating in the therapeutic group could act as a membrane and filter between the intimacy of the group and the curiosity of team colleagues. For example, in the last group I did I had two nurses with me. Previously I had a psychiatrist and two nurses. We observed that it is not important is not the type of professional figure who participates in the therapeutic group together with the leader, but that instead it is essential that those who participate recognise and the value of the group's intimacy both with respect to the patients who participate in the group and with respect to colleagues who do not participate, as well as with respect to colleagues who do not participate.
We call this way of conducting psychotherapeutic groups in territorial services "Co-leading". psychotherapeutic groups in territorial mental health services, a mode characterised by the presence of colleagues who are a bridge between the field of the therapeutic therapeutic group and the field of the service, hence of the working group. In my experience, if there is not this bridge, a group within a service has a short life and also very limited possibilities for treatment. This is the first element, the first bridge function. The second bridge we used, I use the we in reference to the experience shared with other colleagues, especially with Giuseppe Saraò, is what can be called call "the resumption", consisting of half an hour of time after the session, in which meeting the conductor with the co-conductors. The purpose of this space is to metabolise elements that were touched upon in the session and that remained there suspended, as if in some sort of interstitial dimension, and which can precipitate on the subjects, whether they are patients or operators. I give an example, an example that I also reported in an article. There was a session. In that group there were two nurses, an educator, the conductor and nine patients. There was a very agitated patient, very distressed and next to him a

nurse. The nurse tried to talk to him and even managed a bit to be heard. Then the nurse put his hand on the patient's knee and the patient
threw it away from him. The nurse kept quiet for the whole session. During the resumption, he recounted that the patient reminded him of his son who at that time was 24-25 years old and had been a very problematic teenager. So the nurse had empathised with the patient through this internal object which, however, in his experience during the session had been, I won't say damaged, but somewhat "touched". In the "recovery" it was possible to take up this element suspended and metabolise it together with the nurse colleague. If there had not been a resumption of this session and then the next day that patient came into the consulting room and found this nurse there, could they have been able to metabolise on their own what had happened the day before? In my opinion probably not. Something always remains outside, in fact, maybe a lot always remains outside, a little suspended. But having a second bridge like this helps a lot. What we tried to reflect on most with Giuseppe Saraò concerns the idea that there can be bridging spaces such as the shooting, the co-conduction itself, in which it is possible for undifferentiated elements to be deposited that can then be somehow approachable and usable.

Question: Again, thank you very much for this answer of yours, which puts very clearly the relationship between function, context and function of care in relation to elements that present a gravity, a seriousness and that instead, through a series of mediations, can be processed. I would like to compliment you on the clarity with with which you manage to communicate such complexity, rich in traditions of thought as well as clinical. In particular, the exemplifications are very effective, so thank you again.

Answer: Yes, thank you for recognising that, but it is also a simplification. Is also useful to simplify.

Question: You know, simplification always makes me think of the scores of works by Mozart, where the music seems very simple (but is complex). Do you think, Livio, that in public treatment facilities there is one format of group therapy to be preferred to another as more specific and more stable? I am thinking for example of the focal group or the thematic group, as opposed to the tradition of the analytically oriented group which is usually not open-ended, is semi-open-ended so it has new inputs and has exits progressive in time, in other words it has a more longitudinal temporality. While in institutions we often see that there are various formats linked to different types of temporality and different thematicity. So I ask you if you have made any reflections that can make a difference between this analytical group format semi-open, let's say, which has an unspecified temporal duration and

which is also practised privately, and the format practised in the public institution: do you think there is a difference in this respect?

Answer: It may be useful to recall that modern epistemology identifies the scientific specificity through the internal coherence of discourse. It is also for this reason that psychoanalysis can be recognised as a science. I mean, regarding to the question you asked, that it depends on the culture that has that specific service. Services, in my experience in mental health, are on a continuum that has two poles. On the one hand, there is the culture of care aimed at restoring the adaptive capacity of the individual, of the person attacked by the illness, and these are services that inevitably work a lot on the symptom, on the ego functions and then on the rehabilitation of these functions. Within this type of service, in my opinion, since the culture of treatment is not a psychotherapeutic culture, but a psychiatric-rehabilitation culture, then here it does not makes sense to do groups as we have done, i.e. groups with an analytic purpose groups revisited, as far as the conducting model is concerned. Within this type of service culture, it makes sense, for internal coherence, to make focal groups: on a symptomatological manifestation symptomatological manifestation, on an activity, on a phase, and so on. This is because it helps the treated persons to be more able to function with respect to that element identified in the group focus. Everything that is done in day care centres, in rehabilitation, with the so-called intermediate objects, is within this sphere that is a sphere of great value, of great dignity, in short, fundamental. They are interventions that concern ego functions and are aimed at restoring or increasing the person's person's adaptive capacity. Even Claudine Vacheret's Photolangage groups you know, even such refined, analytically refined groups that nevertheless based on an intermediate object, in a way fall within this scope. As you know, Vacheret's conceptualisation is focused on the fact that the psychotic reduces the thickness of the preconscious, thins it out, so it is easier to delude. And, precisely, the model of the Photolangage group is aimed at widening the thickness of the patients' preconscious, thus 'thinning' the illness. This type of intervention goes beyond the functions of the ego, but we are always there, on the functioning and ultimately on the expansion of the person's adaptive capacity. On the other hand, a service that has a psychotherapeutic culture, therefore one that deals not only with regard to how that patient's mind is in relation to the life he does, the context the things he has to do, but which deals above all with how that person's inner world is, then in this case I that person, then in this case I think that the most suitable, most relevant groups within the internal coherence of the treatment process, are groups such as the ones we we have done, i.e. analytically oriented groups. This is a way of working similar to what the British do in their therapeutic communities, i.e. encouraging the development of people who think and who can be quite in

touch with their feelings. My experience is that in the services lately, since the corporate 'savings-performance' culture, based precisely on saving and counting of individual performances rather than on the evaluation of the effectiveness of the care processes, services that had a psychotherapeutic set-up have found themselves stifled and therefore pushed more and more to go on the side of a culture of care of the adaptive type.

Question: Let's say, the things you are saying on the one hand are more than agreeable, on the other hand they raise questions, at least on my part. So, a joke that comes to me is this: nice to work only in the privileged conditions, for example where there is already a psychoanalytic or psychotherapeutic culture in place, as opposed to where there is a rehabilitative culture. But the group analyst, if he has a look at the group institutional group, how will he work instead in difficult situations? (Will you pass me the little provocation). Point two, you spoke of the field. Now I did not asked you what is your conceptualisation of this notion of the field - group field, field shared by a group, or even by an institution or by such and such an institution in relation to another. But then, what about the institutional field (again, an irony to provoke: the tradition of city competitions comes to mind)? in mind the tradition of municipal competitions in Tuscany, the wars between individual Tuscan municipalities, in short, the Guelphs and Ghibellines)? Do we have territories that fight each other? Or is it possible to think of health territories that naturally have different cultures different, but which a group view of the overall field can bring them closer, to make them not only rival, but such as to develop a propensity to collaborate, to work, to develop a synergy, to be thinkable, to be made thinkable? I don't know, I put the question in terms that are a bit a bit too complicated. If it is understandable, perhaps with the answer you can make it clearer. Thank you.

Answer: I will say something about what I understood of your question.
Regarding my conception of the notion of field, over time for practicality, I have found myself using a conception of field proposed by Antonello Correale: it is a conception that distinguishes current field and historical field. This allows one to have a focus both on a present field, let us suppose during a session, and also to have in mind the historical field with the deposits of longer longest permanence. Absolutely not, this is not about waging war between Guelphs and Ghibellines. Our last our experience was precisely in the sense you say. We founded a Laboratory on groups directed by Giacomo Tessari and coordinated by Giuseppe Saraò and myself, where there were psychiatrists and psychologists both from the Florentine area and the surrounding areas. It was also made up of colleagues who had no analytical training, but who were willing to activate groups in their services trying to develop together, in a heterogeneous manner, a thought on groups. E this

could have something to do with the effort, the commitment to develop in the services a psychotherapeutic culture in the services. On the first question you asked, if I understood you correctly: an analyst who does analytic groups within a service that does not have a psychotherapeutic culture can still develop a psychoanalytic sensitivity and thinking? Can he do so?
Is this possible? I believe that it is possible to the extent that first is done
all the work on the guarantors of metasetting. It is first of all a question of sharing and being able to have the meaning and functions of what you do recognised by those in charge of the service, to psychiatrist colleagues, to psychological colleagues, but also to social workers nurses, educators. If you cannot start from this sharing, from this recognition, you can perhaps a lot of effort but, in my experience, it is difficult to collect something. Instead, by doing all the work of building the guarantors of the setting, like what I was telling you earlier about the model of group co-leading and therefore also a work of connection between setting and metasetting, between group and service, then yes, then I think it is possible to collect something.

Question: I think you have, in fact, clarified with your answer also the contents of my question, which was a bit rambling and probing. That is, you said that the analytical function, in this case, for example, let us put it in a service where there is an anti-analytical culture, to put it succinctly, is to make aware what is the reality to be faced, to be processed, to be either transformed or not to be able to transform for example, to either collaborate with or not to be able to collaborate with. In short, recognising what the needs, expectations, cultures, styles of a context are. This is certainly the in effect analytical answer that a group analyst can give. It came to me a painful but very respectful memory came to me. I did a group supervision group in Tuscany in Sesto Fiorentino, which lasted one session. There were all psychiatrists from different churches, to put it that way, from different schools, they seemed to collaborate and they also each seemed to have their own point of reference, however respectful of everyone else's. And the session was unique, that is, it was a session of clarification of the impossibility of working together, but also of the courage of being so many different individuals. This of course also made it clear that there were gravity, there were thoughts about gravity, there were also strategic, political strategic, political management of that service, complex and I, all in all, have retained a frustrating memory because the supervision was not born but, on the other on the other hand, the thought of a session that had made a recognition.

Answer: Maybe I understand what you are referring to. I believe that one can always find a thought, a meaning and an analytical value for any experience. My idea is that in the situation you recounted in Sesto Fiorentino the setting was not well prepared: the setting: the head physician who had

invited you, could not or failed to prepare, sufficiently prepare a guarantor function of the setting.

Question: But what I would like to reiterate is that the let's say analytical gaze is to recognise realities, not to force reality, but to recognise reality and establish what one can and cannot think and do and organise. So, for example, that memory of a session that did not initiate a supervision but was a recognition session is true, yes, it may have been frustrating, but it was also an act of birth. That is, a group that is born and then does not comes into being, does not continue, is also a fundamental experience. I even think that an analyst in his or her mind must have had this experience of groups that cannot can be born, of groups that are interrupted at the beginning, but that have had a strong meaning all the same. So, with respect to an area where for example institutions that have one cultural style or another, it also seems to me so important is the gaze of those who not so much decide whether one can or cannot do that group or that other, but who identifies the characteristics, styles, cultures and then the choices that can or cannot be made.

Answer: I agree, as in: learning also from the experience of impossibility of births or impossibilities of developments, both with regard to the analyst, the as regards the service, the working group. During my years of work in the health institution, I can say that I have not encountered anti-analytic situations, but rather to have encountered non-analytic situations. Even when I have found it difficult to share, I have not had the experience of finding myself 'against', but rather the fact of finding myself and having to stand on the threshold. However, there on the threshold one can stand. Maybe you have to be willing to put in the time, patience, desire, dedication, but then slowly you can, how should I put it, ajar that door. I happened to work with colleagues with very different ideas different from my own, from, for example, biologistic ideas of psychic illness, but one can can be put together, one can work to develop the strength of heterogeneity, but it is also true that it is then necessary to be able to do things, to be be understood, to be able to generate new experiences together with others.

Question: Thank you Livio, you were very punctual and this last note on the heterogeneity and homogeneity of situations, as well as a reminder of your beautiful contribution to Homogeneous Groups, when you were part of the Argo, makes me think that we understand each other very well and also makes me wish to seal this conversation of ours in this way, i.e. by comparing the needs of homogeneity and the needs for heterogeneity that develop in a group. Perhaps this is something that is particularly pleasing to me. You have been very generous and very clear and it is not easy to be so effective in a

conversation that conversation that after all concerns one of the most serious situations in
group psychotherapy and the analytically oriented group, i.e. how the structures of therapeutic communities, where patients are certainly very difficult to treat, where the social and health situation itself can present so many austerities. Therefore, thank you very much!

Answer: Many thanks to you too! What came out tonight is the result of both of us, the result of our meeting. And I'm really happy to I had the chance to go through, and see even better, a long piece of my working life. Thanks again!

Greeting: Let's say it's a conversation full of history. This edition has just a historical character on the development of studies, research and clinics of the group in Italy over the last 50 years, and our conversation has been rich in history also personal and of ties and relationships.

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