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*Group psychoanalysis: 50 years of work report*

# Interview with Corrado Pontalti

*edited by **Nadia Fina***

**Question:** I thought I would start by asking you for a brief historical introduction on group psychotherapy and its evolution. I would then think about your reflection on the different paradigms that we can identify in the big house of group psychotherapy. I will be interested in your point of view on the non-therapeutic clinical groups that are increasingly active in the services, more and more a necessity involving professional figures not always trained in this sense. I will be interested to know what you think of Kaës' concept of extension of psychoanalysis and think of the group as an anthropological organiser of the mind. Finally, referring to your article in Plexus about the current difficulty in forming therapeutic groups, I would ask you to go into this. I'll leave you free field, you can range as you wish: associatively, for more logical connections, starting from your long and wise experience. Ours is a chat, let's start wherever you want and I'll follow.

**Answer:** Group approaches occupy our twentieth century in all the forms that the literature on the history of groups has well illustrated, but I will not dwell on that. Instead, I am interested in dwelling on the paradigm that affects the social more broadly. We trace the group as a healing setting back to the work of Bion and Foulkes. It was born to help soldiers returning from war, the disorder that only many years later would be called 'post-traumatic stress disorder', linked, not by chance, to soldiers returning from the Vietnam war. But, apparently, at the beginning the idea of the group as a setting was to be able to manage more people within a setting. Bion's genius was that he succeeded in founding one of the most significant strands of group history, a thought that later also served for institutional analysis and for the understanding of the dynamics within the institution. Then, years later, another phenomenon occurred that was not secondary. Namely, the '68 movement. A great socio-cultural movement, and I might say one of anthropological significance, which beyond the drifts it generated, was in any case the emerging outcome of the profound reshuffling that was taking place in all the metasocial and metapsychic orderers, as Kaës would say. The codes of the western world no longer read the changes taking place. 1968 was an epiphenomenon that radically transformed relations between generations, and gave rise to a crucible of thought even on mental illness and psychiatry. Basaglia wrote his book *L'istituzione negata* in '68 and drew on the English, French and Argentine experience. A flood of tributaries fed group epistemology and clinics in Italy. Arriving at the conceptualisation of the outpatient therapeutic group, not only private, actually started from thinking about groups and the logic of community therapy. We think of Diego and Fabrizio Napolitano who then opened Therapeutic Communities in Rome and Milan. Two private therapeutic communities in a completely different context, but they lacked social oxygen and therefore closed. But out of that closure came a plurality of registers and gradually the first group associations. In that crucible, around the 1970s, the first group associations were born. A plurality of registers, I would say, starting in the 1970s: Ferdinando Vanni, Diego and Fabrizio Napolitani precisely, Salomon Resnik in Padua, Leonardo Ancona, Francesco Corrao, Ondarza Linares, Paolo Perrotti, Gino Pagliarani, the Lemoine couple (and maybe I am forgetting someone). In short, it was in that crucible that the first Group Psychotherapy Associations were born. But for a long time it remained private knowledge. I am thinking of Morrone who brought the thought of working in groups to Rome. He worked in the Psychiatric Clinic of the University of Rome but the 'group instrument' was mainly for training purposes, it was still 'private' knowledge. The various emerging associative dimensions had fairly precise personal and territorial anchorages. These associations did not start from a model, but from the object with respect to which they had begun to aggregate. It was the context that determined a way of proposing a theorisation and a therapeutic practice.

There was no a priori. In those years, the constraint was 'where I operate'. Think of Vanni and the early founders of APG. It was linked to Vanni's work and thinking. In Veneto around Resnik and the psychiatrists who trained with him. The bond was on serious psychiatric psychopathology. I am thinking of Leonardo Ancona who proposed to Napolitano that a group be set up in the Gemelli psychotherapy outpatient clinic. All subsequent training was substantially 'private'. The construction of an epistemology arose from operativity, from application. These differences bound to the clinical object, became a definition of associative identity. There was the double constraint: the leader on the one hand and 'the place' of clinical work on the other. This is the combination of the constraint of the place in which you work and the identity force of the school leader.

**Question:** So what you are saying with this is that these school leaders have not contributed to building real models between them.

Answer: There is a methodological misunderstanding in our usual language. The construct "model" is used as if it were a heuristic datum. In reality, epistemologists define 'the model' as that procedural practice in search of a theory, not derived from a theory. The set of theoretical frameworks define the epistemological whole that offers meaning to therapeutic procedures without making them procedural a priori. The construct 'model' is very dangerous because it is a semantic combination of two irreducible domains: knowledge and procedures. It is obvious that the more knowledge is in the psychotherapist's possession, the more his competence in understanding the phenomena with which he is confronted increases, and knowledge, by definition, is multiple and not necessarily coherent with each other. Instead, the procedures with which one deals with a psychopathological situation are bound to the unique and irreducible characteristics of the situation itself. Competence in understanding the broad, personal, family, social scenarios of clinical situations is, unfortunately, little studied and little transmitted. And already here the thought runs to Kaës.

**Question:** It is very interesting, because when we refer to models, we are actually referring to currents of thought. I am thinking of the complex and composite reality of COIRAG for example.

**Answer:** Of course. In fact, the difference is semantic on the same field. The field of work has become 'the model', which has increasingly become in turn a dimension of social identity and not a heuristic dimension. I was thinking, for example, that the first Faculty of Psychology opened in 1971. So the Social, on the wave of the '68 movements, on the challenge brought by Basaglia with the book *L'istituzione Negata* (of '68) takes on the drama of the seclusion of the

Mentally Ill as its own responsibility. The understanding of mental pathology, then totally ignored by the psychiatric academy and now totally ignored by the psychological academy, was in fact necessarily to be connected to a humanistic knowledge called 'Psychology', to be formalised in degree courses. In those years, all psychology graduates, for example, worked immediately in the National Health Service. At the same time, in a chaotic and conflicting form, the problem arose between the institutionalisation of the degree and training in Psychotherapy. This problem has not been resolved in the slightest. Suffice it to recall that the regulation of Psychotherapy with respect to the degree is a good 18 years later. Even today, the legitimisation of Psychotherapy practice is for the most part outsourced to Private Schools recognised by the Ministry, which only exercises an increasingly obsessive and bureaucratic control over more than 400 Schools that parcel out at least seventy or so 'models' with an almost evanescent epistemology.
Until 1989, and for many years to follow, what was the Sociology of Psychotherapy training? I cannot enter the subject in an extensive mode. I confine myself to our common interest in the acquisition of competence with respect to the group clinic. It was a very artisanal work due to a few people (our founding Heads of the first Associations) who aggregated students, with respect to an interest in 'the group' without defining the great discontinuity between the 'therapeutic group' construct in the abstract and the 'therapeutic group' construct bound to the places of treatment (institutional constraints) and the psychopathological characteristics of the patients (clinical constraints and skills). The problem is that we often speak of a group without actually specifying what we are talking about and this is an as yet unresolved problem. What kind of group is it? Is it a seminar? Is it a clinical group? What is the socio-anthropological dimension of the group we are talking about? It is still difficult to explore and if you ask you are perceived as persecutory.

**Question:** It is still difficult to stop and reflect, because it is something that becomes destabilising for those who receive this questioning, it shocks the logic of the 'model'...

**Answer:** Yes. Asking what we are talking about when we talk about a particular group is necessary. It is like asking a surgeon what he or she operates on. We cannot think that surgeons are united by the operating room... what do you operate? The epistemologies and languages you have to use are different and incomparable between groups. The sociology of groups, on the other hand, has lent itself greatly to definitional misunderstanding. There is a very strange collusion within the epistemology of psychotherapies, and in general of the mental, in using nosographic definitions typical of psychiatry and the various DSMs to go and define the patients of one's group. The word 'group' is as if it creates a kind of smokescreen that is very

dangerous for clinical efficacy and its evolution in terms of clinical competence. If the constraints highlighted above are not well defined, with clear, precise and non-generic anchors, misunderstandings are continuous. The risk is that you no longer know which object you are talking about, because the group itself becomes a sort of iconic stage set and every group seems to have the same dynamics. Specificity ceases to be epistemological. This is the drama even for theoretical progress.
In the 1980s, this was the historical scenario. Professor Ossicini, in his expertise as a psychoanalyst, professor of Psychology, and Senator of the Republic was the bearer of a very lucid and prophetic vision. Increasingly, thinking in terms of Group Psychology and Clinics would have been indispensable in offering and seeking meaning for the suffering of institutions, for the suffering and psychopathology of individuals. He summoned the above-mentioned group leaders, authoritatively pointing out that remaining fragmented would have meant being completely irrelevant, with no future. He then proposed to found a single association. Thus was born, in reality, the COIRAG Confederation, within which each association speaks of itself to all the others and defines itself with its own statute (in the illusory chiasma between statute and model). A misunderstanding is thus generated that continues to exist to this day! It is so true that several Associations of the first hour did not even stand the lax form of a Confederation; others, over time, were added, always with the prerequisite of institutional safeguarding of their own identity and social identifiability. One must always safeguard one's own model!

**Question:** I would like to ask you Corrado, regarding what you were saying earlier, referring to the great cultural revolution of '68, if you believe that in our era we are experiencing equally profound anthropological and cultural changes. Not in an evolutionary sense though. There are shifts today that make one think, compared to '68 when the thrust was evolutionary, of an entirely involutional thrust. Archaic forms of thought, a reduction in the capacity to think. It is an anthropological change that we are experiencing. I was wondering if the group can be a bulwark against the restriction of thought.

**Answer:** Following your reflections, I could tell you that I have always tried to grasp the indicators of this transformation you speak of. The mind actually organises itself on contextual codes of that specific historical moment. The difference in the expansive movements to which you refer I keep mentioning, recalling that when I started, and for at least twenty-five years afterwards, we immediately put patients into groups without having to prepare them beforehand, assuming as a group field precisely this drive that made the group itself an evolutionary experience. Today the involutional dimension

makes the group become an evolutionary proposal antithetical to the involutional need collectively shared. This is why it is so difficult to establish therapeutic groups in private practice. Patients are terrified of the proposal and psychotherapists are very comfortable in the dual dimension. The time of Covid is perhaps changing some assumptions. Adolescents, for example, who previously did not want to enter the group, are now open to the therapeutic group. They talk about themselves, they need introspection and mentalisation. I am talking about groups of patients aged thirteen to eighteen. The group field is a community field. Think of the parents' group for example. The sense is that of a feeling of Community. Being Community is a first response to this involution you were talking about. This poses the problem of training group therapists. How do we manage this together with the personal mental dimensions? New training is needed, but it must be able to start from the origins. That is, what do we learn from these new 'objects'? Knowledge is not a priori, I said, knowledge is in the object. Here comes an interesting piece of history thinking about COIRAG, which has not taken on these changes as a cultural theme to generate reflection. It always remains a place where everyone tells their 'models'. The founding illness of psychoanalysis is that there is no accumulated knowledge, but rather there is the knowledge of my own identity 'little group'. Associations established on group clinics have also followed this methodology, they have not posed themselves with a propositional epistemological force. Like the Family Therapy Societies that have made no effort to understand how the family has changed over time. They have remained to a more or less effective conceptualisation and language, but which basically serves to define associative membership. Your question about the group field and group thought as a possible bulwark against involution by becoming a political thought, makes me wonder how it can be made so if group therapy associations are all sovereignist? However, for our COIRAG I have hope, and the hope stems from the fact that the COIRAG School has been a truly national school for some years now, with an order that gives ample space for teachings and seminars dealing with sociology, anthropology, philosophy and legislation. Young specialists will be the future if COIRAG succeeds in becoming a unitary and not a federative national association.

**Question:** Are we talking about secular knowledge or religious/ideological knowledge?

**Answer:** This is precisely about the sacralisation of theoretical and procedural assumptions. There is no evolution. The problem that has always arisen within psychoanalytic associations concerns precisely this question. One cannot question, either in theory or in practice, the 'sacred' assumption.

We talk about the heterodoxy of the sacred that evades the question of efficacy and the problems that analytic practice poses to us.

**Question:** You make me think back that in Milan, in the 1970s, a series of lectures on psychoanalysis were held at the Umanitaria outside the analysis room, and I have memories of great masters who tried to combine psychoanalytic thought with social phenomena, dealing with social phenomena and crises as generators of pathology, in order to free the patient from the family novel in the strict sense. The family was there in the gaze, but the family itself was a cultural and social derivative. An anthropological expression that carried suffering within itself and transmitted it. I remember following these evenings with great interest. At some point they disappeared, suddenly and in absolute silence. As if this vital thrust had stopped and it was difficult for us participants to understand why. A ferment that failed to turn into a common work project. No article, no writing, nothing.

**Answer:** Yes. Here comes a fixed thought of mine about anchoring to one's own sacred assumptions that made the object of study fail. We do not have adequate studies on the validity and effectiveness of our work. Failure must be the object of study. The failure of the therapeutic project, for example, is instead deputed either to the patient's resistance, or to the wickedness of the family and electively to the mother. Or to the therapist's counter-transference. This does not open up a heuristic field of knowledge. We must ask ourselves whether the therapeutic system we put in place corresponds to that specific clinical situation.

**Question:** This consideration seems particularly relevant to me. I am thinking for example of our trainees, when in their final theses they courageously bring up the difficulty of working with a patient. Sometimes perplexity arises in the committee. Instead, I believe that this is a valuable moment that should allow a comparison....

**Answer:** Of course! It should be a moment of confrontation as a cultural, clinical, theoretical theme. If this does not happen, psychoanalysis, and psychotherapy in general, is completely deprived of any possibility of being that driving force to which you yourself referred. As you know I frequent many psychotherapeutic realities, from family to cognitive, for example, but the problem is the same there. I remember, for example, a case of an anorexic girl presented at a family therapy conference as a paradigmatic case of good practice. Some time later I asked how the treatment had proceeded. Dramatic answer. The girl died. Did a paper appear, a note to reflect on the gap between paradigmatic case and death of the patient? It is necessary to reflect on this outcome and so many other failures, not to blame of course, but because if I

erase these events I lose the opportunity for a 'knowledge' that we have not yet been able to have and that can instead become clinical knowledge.

**Question:** What you say reminds me of the discourse of the extension of psychoanalysis according to Kaës, which basically tells us that we have to work a lot on the blind zones and on those deposited residues that should not be neglected and should be understood, because otherwise not only do we ignore the psychic and relational phenomena of our suffering patients, but we do not succeed in widening the field, the gaze. Widening I think means precisely widening our gaze, understanding and thinking around what we are not yet 'able' to see. The risk we run is that we lose the patient, in the sense that it is he who we no longer see, that is, we see him according to our theoretical model, which in fact risks being a closed schema.

**Response:** But in fact... with Franco Fasolo I remember that we used to say "it is we who organise the chronicity of the patient, and the chronicity is not of a psychopathological picture but of life. It is life that is chronicised!". All stories begin in childhood and adolescence. We think of child psychoanalysis and developmental neuropsychiatry that has to come to terms with the fact that young patients today are given psychotropic drugs. Over the last ten years, in an incomprehensible way, this phenomenon has increased. What has happened? Is it a failure of child psychoanalysis? We have to ask ourselves this in order to understand, to start again. You have to assume failure to understand what has not worked, to get out of the self-consolatory logic of the patient's defences or the mother's wickedness, to go instead to ask where the project and the articulation of the therapeutic project is effective and where it is not effective. That is the question! Where it is not effective and why. We must come to be able to reason precisely on this. For me too, the problem of extension is a significant hook that bridges the total autonomy of the social with respect to its metasocial and metapsychic guarantors, it completely frees us from a logic of the intrapsychic mind to urge us to understand how history has changed them, how history has changed the perception of the mind. The borderline between what is the most radical mourning of psychoanalysis. That is, can I conceive of it as an important knowledge alongside other knowledge but not binding only to the organisation of therapeutic fields? Because the death of psychoanalysis for me occurs when the setting is bound to the sacred of epistemology. So, for example, does leaving the setting mean leaving psychoanalysis? Does the conceptualisation 'extension of psychoanalysis', which I share, involve the possibility of modifying therapeutic projects or not? If you do not modify it, if you do not assume the possibility of this modification, then we lose the meaning of the extension conceptualisation. Extension means modifying the project, as a consequence of the epistemological transformation.

**Question:** And you think this is not clear in Kaës' formulation?

**Answer:** No. Absolutely. He should bring us clinical stories in which he extended the therapeutic fields.

**Question:** It is a concept, according to what you are saying, that can allow a reflection but it is not a concept that can contribute substantially to modify the therapeutic project.

**Answer:** Absolutely. Extension, I repeat, means that you have to get out of the sanctity of the setting. You have to get out of the norms that come down through the generations and no one asks what meaning they have today. We have to be prepared to think and welcome radical transformations. As with any knowledge. So how do we conceive, for example, the therapeutic group field? As a field that recapitulates the other social dimensions. But if this does not happen, I will, for example, continue to dislocate the dimensions of the patient's life outside the strictly therapeutic setting. To extend does not mean to dislocate, it means to assume. To extend does not mean to include other therapists, it means to take on the existential and life dimensions of the patient in terms of actually understanding the textures of the trans-individual mind. Thus, therapeutic practice is completely modified. This is actually simpler than fragmenting the therapeutic project by introducing various figures. The sacred ritual I was referring to is, on the contrary, an empty ritual devoid of generativity within itself. For example, in all Therapeutic Communities, in all services we do groups, but this in itself does not tell us whether the group is therapeutic, that is, transformative of the mental. The therapeutic objective requires the competence to activate and manage the intersections between the patient's established history, his psychopathology, and the institutional and mental organisation of the Service. If this does not happen even 'group-making' becomes an empty ritual. What is the fundamental challenge of a therapeutic group? The unpredictability of the phenomena that can occur. You must ensure that the group always remains on the border of unpredictability.

**Question:** The group must experience conflict. The therapist must make conflict possible. Let's think of adolescents today who in the family group encounter parents with narcissistic problems who demand confirmation from their children about their actions and behaviour, they zero in on the conflict they do not know how to manage. Adolescents do not know how to have an emancipative experience of conflict and so we see violent drifts, for example.

**Answer:** The question in fact is what makes a group therapeutic today? Always reading the collusion between what we consider to be maximally therapeutic and social functioning is important. Today even more than yesterday there is the conviction that the dual relationship is the maximally effective one, thus espousing the individualistic logic of this historical and cultural time. It is collusive because it becomes specular. The reticence to form groups also stems from the fear of the complexity that this multidimensionality entails. The unpredictability of the individual's reaction to the group setting activates the phenomenologies of transference scenes. The group field, intense as a matrix of unconscious meanings, activates group transference scenes in a continuous processuality between transference of family scenographies and transference of social scenographies. The individual patient is thus confronted and disoriented with these basic oscillations. This leads to the fact that severe patients will leave the group unless they are accompanied with personal supports by the same group therapist. It is essential that it is the same therapist in order to maintain consistency in the re-weaving of the mental. Otherwise they would not hold the tension in relation to their own internal drama. They are very complex patients. The problem is how I manage the mental. The problem with extending psychoanalysis is what do you extend? It is not enough to extend knowledge, you have to extend and integrate the therapeutic fields, where knowledge can take meaning: intrapsychic field, family field, social field. Electively, the therapeutic group field becomes the symbolising matrix, for the personal mind, of the interface between Family and Social. It is for me Winnicott's true and heuristic transitional area. The blind area of understanding, but the blind area is a problem about knowing, it is about how knowledge is constructed and not just a problem of the intrapsychic unconscious area. The problem is that seen this way the group field questions the rituals of psychoanalysis not psychoanalysis. The enormous knowledge that flows from the great landscape of psychoanalysis is activated not through rituals but through the signification of the phenomenal emergences that the various therapeutic fields activate. The horizon to strive for is, therefore, to make it possible for the patient and for us to sustain the awareness that one's Self is a Community that lives because it is in a Community. We must be aware that this progressive plotting generates anguish for the dissolution of individualistic and narcissistic positions. What primary anxieties does being a Community activate? Anguish, therefore, is a mental neo-formation. It is an extension that generates a mental neo-formation. So anguish is not, in this sense, an extension of the intrapsychic unconscious. As therapists we have a social mandate. The place of the neoformation of mental competence is the current challenge.

**Question:** You make me think of how much this has to do with psychoanalytic institutions, to think of themselves as a Community that produces thought but also projects for the social. We spend a lot of time finding the best possible solutions to cure but what is the mandate we have?

**Answer:** If we think of the Manifesto of the Order of Psychologists, which appeared a year ago, the dominant term was 'discomfort'. Discomfort is not included in psychopathology. This means that we have taken ourselves out of 'mental illness'. What social power can we have then? How do we contribute to reducing chronicisation? This is also an ethical challenge. Ours must not be one of many professions for the sake of well-being. We must change the epistemology of care projects.

**Concluding comment:** Thank you Corrado for everything you have said, but also because you give us so much food for thought. You have reminded me of many challenges in the distant years when there was the generativity of psychoanalytic thinking. We have to learn from history to move forward, to gather further stimuli and pass them on.



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