A supervising experience within an institution

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Abstract

A experience of supervision in a former asylum, transformed about a decade ago into an R.S.D., a residence for the disabled integrating basic assistance and sanitary care. The search for a unified interpretation of the institutional field, its great founders and its implicit rules, as a path to reduce the anxiety and the subsequent block on the vital energy needed in order to change. This energy had been a long time catalyzed by defensive mechanisms indispensable to those who work within the guidelines of the 'relationship of helping' in the residential context.

Keywords: Supervision, multidisciplinary team, regression, expectations and omnipotence

A few kilometers from Monza, there is a large complex located in a park. At one time, it was the site of an asylum which was rather well-known, if not only for its size and its history. This huge complex became a mental institution about one hundred and fifty years ago in what was once the summer residence of a noble family. The villa and its wards quickly took on a sinister reputation, and the walls became a divider between the civilized world (influenced and fueled by the presence of the asylum which provided employment to many locals) and another, full of suffering and sadness: a real and true city of psychiatric horrors which would end up containing up to three thousand patients. To date, a good part of those structures are in a state of serious deterioration and abandonment. Only a few pavilions have been salvaged. In particular, one has taken on the name of RSD (Sanitary Residence for the Disabled) in the last ten years. Above and beyond the name, however, it is still home today to people who were born (literally) in the halls of the former mental hospital. They have spent their entire lives there without ever having ventured out of those walls. Similarly, there are also people who have been working in this place for decades. The transformation set off in 1978 has made of these people living witnesses that the process has not yet been fully completed. The asylum no longer exists, but some of the people who inhabited it continue to do so. This is a contradiction which creates a state of crisis for the institution itself, those who live there and those who work there.

It's hard to think you can confront with the same psycho - social and educational strategies both people with disabilities and people suffering from psychiatric disorders. This attempt makes it so that the working group has to face multiple levels of crisis: in the first place, on a methodological level. The task at hand of the place can not adapt and, for that reason, there is the necessity to use a 'single sewing needle for very different materials'.

I remember well the day when I was introduced to the team to begin my work as a supervisor. The question I was facing was focused on the difficulties of

communication that existed both within and between different groups of workers belonging to different professional categories. The themes of the first meetings were linked to the long-established incapacity of communication. In addition to this, we also talked about the history of the place and the culture, inside the structure and of the country to which it belongs. Speaking of the history of the place means, beyond the culture that accompanies it in its evolution, its myths and a web of unspoken rules often rendered unclear by a lack of awareness of their existence in spite of them being in some measure accepted and shared. Those meetings carried along but with a rather widespread sensation of a block in the communication processes, a long-lived deadlock and an impossibility to access any sort of change.
The weight of individual anxiety grew until it became intolerable. In an unknown attempt to get rid of it, it stimulated its transmission on a non-verbal level (a certain lack of care in assisting others, death, physical and mental illness, contamination, etc.). ‹‹*The anxiety of which we speak of is rooted and controlled by an entity that can tolerate it (should be the institution) or it is experienced as fear of something uncontrollable*››. If it is too large, the Ego defends itself by fragmenting. At that point, it is expressed by projective identification like displacement of the bad parts of an external entity. *‹‹The defensive mechanism against these experiences is typically the formation of subgroups characterized by very rigid boundaries, whose aim is to join together to protect, defend and save. This can create alliances on a large scale in the environment and develop common non-mentalities like anonymous collective defense mechanisms.››* (Ibid).
The lack of awareness, the lack of dialogue, the lack of representation of the elements mentioned above are reflected (in the words of Racamier: mirror effect) as a recurring theme both in the patients and the team of workers. The same division into sealed subgroups included but was not recognized as such among the patients of the facility.

Just as there was an breach between the groups of educators and those of ASA / OSS there was a similar underlying division between frankly psychotic patients and patients with cognitive deficits. Although there did not exist in reality a distinct border, in an effort to respect the declared educational workload of the place, they denied the presence of the first division in compliance with the mission of the institution. This thought entered into the working style creating operational difficulties and frustration. These divisions first between diagnoses and then between groups, caused the operation of the institutional to drop to an archaic level where the basic assumption that prevailed was that of attack-escape. It was a primitive attack corresponding to the disappearance of a world of relationships full of trauma and the unknown. In alternative, there was escape. Escape implemented by patients and operators as evidenced by the request to leave by patiens and operators.
The aspects to that I felt were more pressing were associated with the recognition of the denial on the part of the psychotic portion of the patients. I hoped this step could reduce the burden of anxiety both in regards to the mission of the not quite

respectable, because based on a false assumption (only in the disabled patients), institution and in regards to its model of work and planning of the same. A second pressing element was the quantity of anxiety present in the place due to it's lack of being channeled into a functional entity. The death of a patient or the illness of another are always key triggers to that distress. My attempt was to replace the burden onto the establishment as the entity dedicated to manage it and remove it from individuals. This is only possible if you can implement a recognition of limits and a reduction in the size of the omnipotence that serves as a defense mechanism against those same anxieties. Letting down defenses would have allowed a reduction in the distance and the barriers between groups and, consequently, initiate the recovery of the communication processes and collaboration between the various professionals.

This attempt helped to bring to the surface a functional method that in some ways already existed on an unconscious level, but also resulted in a reduction of expectations and the adhesion to groups where otherwise this distinction could not be obtained. The same can be said with respect to the anxiety of death and disease. The reinterpretation of the deaths which occurred during the period of supervision allowed us to clean out the field of illusions of personal responsibility and categories and included, on the other hand, the death event as part of the life cycle of a structure such as this. If outside of the RSD you know death exists but it occurs very rarely to actually witness it, inside the structure this is not the case. During the course of the year of supervision I also included in the groups the 'hotel' staff to finally arrive at a moment of combined confrontation between all the workers belonging to different professional categories. This type of encounter, called multidisciplinary teamwork, was attended after much apprehension but then proved to be a real opportunity for discussion and, in fact, dialogue.

Certainly, that meeting did not solve all of the communication problems that existed but created a breach in mutual defensive mechanisms resulting in a small space for communication, more related to personal dimension than to the group, but still experienced by all as a positive sign and as an indicator of a direction to follow.

In the subsequent period of supervision, themes emerged relating to the boundaries of the roles of auxiliary and professional educator. This is what one operator defined in a group meeting as " the gray area". This area regards both categories. Perhaps, from a newly created confrontation, emerges the need to better understand and define the areas in which each can and must operate. In other words the expectations determined by an ideal structure, it's partners, determines the need for professional identity, the survival of that identity, value / self-esteem and interpersonal skills which allow the placement of the weight outside of the individuals (on the entity and not on the people who work there) of those psychotic anxieties of ambivalence and division. I will mention again a phrase that emerged during a group meeting: *‹‹If there were no rules, we would like them (the patients) and there would be no distinction. The physical therapists have uniforms which make them recognizable in their role. We are recognizable only because we are the ones who try to enforce the rules. If we don't at least do that, we become their equals.››*

This is how from the incomplete attempt to define the gray area (a better understanding of who can or must do what) we have come to consider as an area of interest not only the limits of the professional categories but the broader concept of the cross-over between the groups and the concept of the well-being of the person, intended as "what the subject perceives as well-being". This observational outlook has made way for a change in point of views that has finally accessed a potential for transformation which was locked and imprisoned at the beginning of our work. Thus, the reduction of the shared anxiety transforms into an operative dimension which is alive and energetic. During a group of OSS (Social Sanitary Operators) someone proposed a solution which may be suitable both for the guests and possibly the workers as well: "Guests who run away ?? … either you put up a gate or you make the place more attractive for them. The flip side is that they have acquired the skills of spatial orientation in the park. "

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