Building a course of therapeutic treatment

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Abstract

The author offers a reflection on the internal/external dialectic dynamic as a central element in the organisation of the therapeutic community's task. This dialectic regards the psychic and relational life of patients who, upon admittance to the community, distance themselves from the healthy or pathological objects of investment that have accompanied them to that point and enter a new context of treatment and relations. In this passage they also carry within themselves their own psychic and relational styles, proceed by trial and error in the attempt to either keep these alive or else try out new ways of being in the world. Communities also experience the tension between the social exterior, with its rules and contradictions–at times so pivotal to the development of a psychopathology, as in cases of anorexia and personality disorder–and its own inner organisation, which must be capable of maintaining stability and coherence in order to ensure its therapeutic function. The function of containment and of institutional container is strongly underscored as a fundamental element, with the suggestion that the boundaries of the community should be built in such a way as to guarantee a sort of semi-permeability that works as an antidote for both self-referential tendencies as well as for excessive infiltration from the outside that would hamper it in its task of providing new conditions for its guests' resumption of their evolutionary journey. The liberating use of aggressiveness is another theme on which the author dwells in the conviction that often the emergence of aggressiveness in patients is considered solely a negative element, while instead it can be a precursor to receptivity to new resources and developments. This happens because the sheer complexity of managing aggressiveness and its transformation into determination and security nullifies it in service of the community's "normopathic" functioning.

Keywords: therapeutic community, containment, interior/exterior, aggressiveness, holding caregiver, Third

Introduction...?

When setting out to write an article – or a book chapter, as in this case – one faces two opposite situations. In the first, the author is the one who freely chooses the title and topic of his study, pulling up from inside that which most interests him or of which he is most knowledgeable. In the second, the topic of reflection is imposed from without, the book's editor, for example. With a view to playing a bit with these two concepts, I could say that I find myself inside the second option in which the title of my contribution comes from outside of me.

The borders of the therapeutic community and the interior/exterior dialectic

The path my reflections sets off from the curious analogy between my position and that of a builder of a patient's therapeutic course of treatment, and also necessarily combines exterior and interior elements both as regards the patient's inner psychic and relational worlds, as well as the community's symmetrically social interior and exterior, this latter outlined by its "walls". The interior/exterior dynamic, or dialectic, informs and shapes all the phases of the patient's course of treatment – intake, treatment, release – since the patient, who comes from the "outside", is asked to accept treatment by entering a community, where perhaps he/she will find psychic pain relief if he/she stays there long enough.

Just as in a complex system of mirrors that endlessly multiplies images, it should be said that the patient brings his/her exterior life "into" the community both directly and indirectly by means of his/her inner representations, recollections and memory removals. The vicissitudes of this more or less tormented exterior/interior relationship will always provide "landmarks" by which to monitor the route and speed of the therapy. (1)

The patient's exterior is set of social, cultural and family factors, of habits and conventions from which the patient must separate upon entering the community. Correale described it well in a 1998 paper in which he proposed the term "preliminary grief" to describe the complex operation that patients and their family are forced to undergo at the moment the patient joins the community.
Indeed, after over 50 years of experience of community treatment, I believe it would be a good idea to acknowledge that the community is possibly the most authentic supporter both of the utility of physically separating the patient from the life setting, as well as of the need for the patient to be immersed, or absorbed, into a "therapeutic environment". This theoretical/clinical "belief" distinguishes it clearly from other outpatient or hospital interventions. (2)
As I said earlier, during the course of treatment, the patient's "exterior" will reappear directly or indirectly "inside" the community in more or less pathological ways. In moments of crisis, there will be demands to be released or escapes, other times family members will sabotage the therapeutic pact in contrast with their declared intention of cooperating with the caregivers. (3) At still others, the treatment will yield a new ability in the patient to reflect on the past and help him/her – and the caregivers – to understand whether to salvage parts of it in new ways and forms, or to painfully but definitively separate from pathological intrapsychic and interpersonal mechanisms now better defined and clear to the conscience.
We can say that the evolutionary quality and results of this dynamic will depend mainly on two conditions. One concerns the ways in which *the patient carries past experiences* (4) – traumatic, confused, destructuring – inside him/herself, and the other the ability of the community to establish itself from the very beginning as a valid container for the patient's psychic experiences.

The therapeutic community and the containment function:
mental/concrete and conscious/unconscious aspects
The concept of "container" and its psychic functions is one of the many things that clinical psychology owes to psychoanalysis, starting with Winnicott's formulation and up to Bion's refined speculations and those of his successors, but I do not think it is necessary to discuss the concept here.
Suffice it to say that today the relational matrix upon which the human mind is founded has been recognised by all of psychology and confirmed by the most recent neuroscientific studies. That is, we know that the human mind needs to have the experience of another mind that conforms with it and contains it, in order to develop and, in turn, construct a container within itself of other psychic and relational experiences.
In the case of serious pathology, once it has been ascertained that something has gone wrong in the encounter between "container and contained", and that offering a patient a good container is the first requirement for launching his/her course of treatment, the problem is how a therapeutic community can provide a container specifically appropriate to each individual patient.
Hinshelwood writes (2014):

> I have tried to reflect on the ubiquitous needs of human beings, of all ages, to be contained, and have come to the conclusion that we have very little thinking about how organisations might be involved in this containing function, for the good or, often, for the bad. It would appear that there has always been a ceaseless demand for it, without the necessary understanding of these processes. As the processes are mostly unconscious, probably only those who are familiar with psychoanalytic ideas can really provide the necessary understanding. (Hinshelwood)

I see this as a fundamental point, because we can sometimes make the same mistake as the ingenuous, and somewhat sterile psychoanalyst (fortunately, these are in the minority by now) who believes that defending the "rules of the setting" is necessary and also sufficient to produce successful containment. While, instead, the "rules of the setting" are not only a technical/material

way to facilitate the therapeutic encounter between patient and caregiver. It is a bit– if I may be allowed an approximation – like mistaking the rules for sterilizing the operating room for the initial phase of the operation by the surgeon himself.
Rather the function of containment is primarily a psychic function (at times decidedly somatopsychic!) that is activated in the therapist's and the group's minds to accommodate emotions, thoughts, projections and somatopsychic states of the patient in order *to make him/her feel at home, and to understand who the patient is and what he/she needs*.
I say mistake, because it is easy for a small organisation to consider the "community rules" sufficient to achieve containment, while instead we must ask ourselves what strategies might work better to ensure that the *minds of the group* of caregivers are predisposed to containing their patients' psychic elements. In the above citation from Hinshelwood, the author underscores the unconscious elements at the base of the function of containment, i.e. those aspects activated in the caregiver's mind that produce containment, because the physical presence and intention of being helpful are not enough to render a relationship therapeutic.
In essence, it is truly difficult to define what "containment" is, and what its rules are, since much of it is founded on the unconscious aspects of the psychic apparatus, and this becomes even clearer when we focus our investigation on groups and institutional or social organisations. Let us limit ourselves to always keeping in mind that the container *is a mental function and not merely a material condition*. Amusing, in this regard, are those communities – and there is no small number of them – in which maintenance of the institutional container is accomplished through rigorous attention to the scheduling of staff or patient group meetings – as if they were no more than scrupulously-orchestrated Tupperware parties!
The container function is used in order to create a place (or a home, in fact!) for the expression of insanity. The psychoanalytic setting is the container for insanity that can be expressed principally in words during a session. The community setting, on the other hand, is a container dedicated to a deeper and more radical insanity that words are not enough to express, since it needs many other less structured outlets *in the routine of daily life*.

A community that acknowledges its first task, both chronological as well as hierarchical, as that of offering containment, must be designed as a container, i.e. principally on the basis of the patient's needs in addition to the undeniable needs for survival of the organisation itself. (5)
When I speak of an organisation designed as a container, I have in mind that it must perform that function for a variety of groups of persons – patients, caregivers, referrers, family members – and be capable of doing so in various ways.
I have mentioned only a few – and in my opinion, more delicate – of the general aspects regarding how to think about the function of containment, of the many that could be discussed but would lead us off our chosen track.

The rules and the principle of semi-permeability
The community is an apparatus for group treatment – a group of professionals treats a group of ill people – that offers its rules as its first concrete element of containment. These are often presented almost as commandments, and their acceptance is considered an important factor in establishing the therapeutic alliance. Some rules are justifiably categorical (no serious acts of verbal or physical violence, no stealing, etc.) because in their absence no form of co-existence is possible; others are or can be more flexible. I think that a community offers a containing environment when its rules are structured around the *principle of semi-permeability*. I am unable to find a better definition for what I mean than this symbolic/metaphorical one, but I would like to be able to suggest more a dynamic reaching out than the establishment of a permanent state.
The community is an institution that should be distinguished by its attention to the semi-impermeable maintenance of its physical and symbolic confines, otherwise it would cease to be a community and revert to being a total institution.
It must certainly be semi-permeable with respect to the social context that hosts it, as is

demonstrated by the ramified complex of relations with the referrers, family members, other institutions, the working and volunteer worlds, during the phase of therapeutic treatment, from in-take all the way to release. I believe that its internal rules should be based on the same principle, i.e. be both softer and more personal, and when necessary more severe, than those of the outside world.
The reason for this derives from recognising some of the violent and humiliating aspects of the society from which the patients come, and from which they must be protected in order to build personal substance. Analogously, this is also what happens within the psychoanalytic setting in which it is possible to formulate thoughts, reveal parts of one's self, admit fragilities that would be unacceptable outside the context of the session.
In a therapeutic community, the rules should be based on a similar principle. Indeed, I believe that this complex issue is perhaps one of the main focus features that differentiates an educational community from a therapeutic one, the former being focused on acknowledgement and compliance with social rules, and the latter on containing the thoughts and emotions of insanity.
Apropos of that, I am convinced that a therapeutic community must have the courage to express a certain degree of dissent toward social rules, exactly in the spirit of Freud's scandalous early 20th century proposal to base treatment on encouraging free association and holding nothing back. A proposal essentially unorthodox even today, given that the unconscious remains the realm of desire and transgression.
Analogously therefore, the community can tolerate within it novel, uninhibited and eccentric behaviour as expressions of our patients' fragility and their transgressive and provocative baggage – personal ways of existing that denounce and reveal the distress of a civilisation.
But that semi-impermeability also works in reverse. It is no secret that the community may find that some rules require rigorous application, especially because part of its role is to act as a social guardian, keeping intemperate and antisocial behaviours within acceptable limits. Above all, however, because in order to exercise its therapeutic function, it must offer opposition to the omnipotence underlying any serious pathology. Therefore, the opposite of what I just described could happen, i.e. that some rules of the community are applied more severely than those outside its walls. Community caregivers could find themselves less tolerant of the social body when faced with some behavioural displays, precisely because they recognise their omnipotent and psychopathological qualities. An example is offered by some interventions by the police who, called in by the caregivers to exert their authority and severity, instead offer all the acquiescence and friendliness of which they are capable, promptly neutralising their effectiveness.
Semi-impermeability in the community, therefore, is a membrane that operates in two directions.

I would add that since the rules can perform the function of therapeutic container, they must necessarily be *clear, consensual, public and democratically co-formulated to the extent possible*. *The most common error is to confuse flexibility with ambiguity*. Ambiguity is already inherent to things human, and all the more implicit to the community system and its social mandate. It is up to the caregivers, therefore, to seek to resolve the problem of ambiguity by using clear and definite rules that are, nonetheless, subject to collective debate when changes in conditions require it, or when its leadership decides to introduce innovations in the treatment.

The therapeutic community and *holding.* Possible balances between predictability and spontaneity, groupality and individuality

The psychic experiences of staff need containing as well, because we now know that the "climate" is one of the most important a-specific factors in the outcome of treatment, and the staff have the primary responsibility for creating and maintaining it.
In an earlier study of mine, where I attempted to apply the ideas of I.Z. Hoffman to the theory and practice of community therapy – those contained in his exhaustive "Ritual and spontaneity in the Psychoanalytic Process" – I maintained that our attention should not be as much on how the real team functions as on the *representation of it that takes shape in the mind* of the caregivers. It is this

element that provides the greatest contribution to the formation of the "institutional ego", also defined as the "syncretic ego" by Bleger. The institutional ego is that part of the professional identity generated by belonging to a specific institutional reality, and that almost unconsciously accompanies the work activities of all caregivers at all times, even when they are working in solitude, such as on a night shift. It is that which determines the good balance between the security offered by the group and the risk of the free spontaneity of the individual. The representation of the team that everyone should have is of a source of safety, that indicates precisely the direction to maintain and coordinates the strategies of the group's work, and that at the same time *accommodates the personal and spontaneous aspects* of its members.
A somewhat deeper analysis considers the need to blur the sharp counterpoint between the *security* offered by the group (ritual, organised, "conformist") and the *risk* underlying individual undertakings. The relationship between the two elements is dialectic rather than antithetical. Indeed, we know from experience how harmful and humiliating a work group can be when it is only able to work in unison, thus missing out on the possibility to avail itself of specific individual contributions. The individual caregiver with his/her spontaneity represents a sort of *metaphoric sense organ* that enhances its perceptive and thoughtful capacity. Otherwise, the group is destined to become a dead, closed enterprise, incapable of creativity and self-referentiality. We would prefer the caregivers to have the mental representation of a democratic team capable of containing various points of view and of accepting, as we said earlier, the dissidence expressed by each one's uniqueness. The risk is that the work group is represented as a dictatorship demanding conformity and whose opinions are rigidly binding for individuals. Such unhappy, but far from rare, circumstances cannot but install a relationship between the group and the individual that tends to limit the capacity for therapeutic listening and the use of talents and inventive skills, and leads the group towards gradual impoverishment. Perhaps this is one of the hidden causes of "burn-out". I would like to be able to say, metaphorically, that what is decided and thought during team meetings represents an *external* and more organised frame for the caregiver's community work, while spontaneity represents a necessarily unpredictable *internal* matrix.

In the hopes of not having gone too astray by dwelling on some of the aspects of the container function, I would like to go back to the treatment, starting with intake. By this stage the relationship built with the exterior, with referrers and family members, is already decisive and indispensable. Since the concept of *resuming the evolutionary path* is one of the ways of defining the purposes of community treatment, we are obliged to ask ourselves what the *conditions upon departure* were of the patient entrusted to our care. Any given patient's path of psychic and relational growth began in other places and other times with his/her first relational and emotional experiences. The community must necessarily have a specific clinical and organisational perspective in order to intercept and examine these primordial origins that have inevitably shaped the patient. This is a delicate operation, during which communities assert their work style and theoretical/clinical orientation. Some require numerous clinical meetings with the patient and family before intake; others go directly to the patient's home to observe family dynamics and to make the request for community treatment stem from there. In each case, providing *a service of structured reception* dedicated to this specific function. The merit of this methodological orientation derives from two theoretical premises. The first, perhaps more obvious and broadly acknowledged today as essential, consists of forming an alliance with the family regarding the therapeutic programme to ensure that it is carried out on the basis of expectations, and is as aligned as possible with the patient's conditions and all the actors' awareness of illness (M. De Crescente et al). The second concerns the aspect of discontinuity that entry into a community represents and that, as such, can be a precursor of new anamnestic discoveries or the unfolding of new meanings.

I mention discontinuity because "repetition compulsion" is expressed in serious pathology as a psychic a-temporality, where immutable suffering and the repetition of unhealthy routines protect from change, which is considered too dangerous and a source of psychically intolerable fragmentation anxiety. Zapparoli spoke of the "constancy of pain", precisely to describe that

defensive operation in which pain is preferable to change because pain offers a continuum that protects precisely because of its predictability and the fact that it can be kept alive. The same can obviously not be said for far less protective "happiness", so much so that its achievement is compared to "walking a razor's edge".

Entering a community represents a break with this continuity as a result of the forceful imposition of time present (and future) as an intrinsic factor in treatment. It is advisable to give due consideration to the fact that this element creates intense stress for the patient, but I believe it is important that clinicians know how to use the opportunity properly, since the present moment becomes an aggregating factor. It can act as a point of departure for going back into the past to understand the narrative the patient has built within; and for going forward into the future to suggest new narratives and working ideas to the patient that, at the same time, constitute both a diagnosis and a treatment project. Every journey (not only therapeutic) has a point of departure and a point of arrival, so being as clear and specific as possible in "personalising" both the patient's story as well as this new start in the community, is one of the tasks of the caregivers assigned to intake. A personalisation process with which the patient can identify and that can possibly give him/her a new self-perspective. Indeed, it is far from rare to note that, during the more or less lengthy phase of intake, the patient is given the opportunity to rearrange the coordinates of that intra-psychic and interpersonal story, to relate facts, thoughts and slices of existence that no one knew about, perhaps not even referrers who have been following him/her for years. Or else, that a new person emerges, a sort of "distant relative", who constitutes a new either concrete or symbolic resource for the patient's psychic life. Emphasising discontinuity is a way of signalling to the patient that entering the community can represent a break from his/her modes of "deferred existence", because awareness of the passing of time, in addition to underpining human restlessness, is also the only framework within which the psychic life can acquire meaning.

Building rapport with the referrers is another important element and must, in addition to faith and collaboration, be based also on a bit of *harsh clarity* regarding reciprocal roles. The alliance with the referral service is founded on a harmonisation of all parties' clinical vision, and is essential to installing and maintaining effective clinical and institutional/administrative relations – especially in Italy, where law no. 180 assigns a central role to local healthcare services. Experience teaches the usefulness of laying out, with *harsh clarity*, an adequate division of responsibilities and institutional functions: who will deal with social and work-related issues, who will suggest pharmacological changes and how, who will maintain relations with the family, and so forth. It is self-evident that a schedule of this sort will vary according to the situation and pathology, and will always be open to revision; in any case, it expresses the intention to work together by fostering the creation of a broader setting and source of security and protection. By way of an example, *particularly in the case of children's communities*, we might think of the clinical management of emergencies and admission to a psychiatric diagnostic and care facility, which inevitably punctuate the course of treatment of some patients. We know that often the outcome of hospitalisation *has more to do with the quality of previous arrangements with the referral service, or with other ward colleagues, than with the acuteness of the patient's psychopathological condition*.

The function of theThird

Another area in need of attention when mapping out a course of treatment is the relationship with the referrers and the theme of the Third.

Considerably strong bonds are formed between community patients and care staff, which sometimes tend to exclude other actors, who are viewed as an obstacle to the continuance of the "true" community treatment process. Teams typically rationalise this unconscious strategy with explanations such as "only we know you", "your family are pathological and need to be kept at a

distance", "previous communities were wrong", "our method is finally the right one", and so on. In my opinion, it is obligatory to be aware of how unfounded such emotional positions are and that they are often the precursors of failure and deep disappointment. There is a sort of *natural antidote* to fantasies such as these that corrupt the team's mind, and that is the referrer, with whom channels of communication and discussion should be kept as open as possible. It is necessary to factor in a certain amount of effort to achieve this because we are not always certain they will be willing to stay involved; on the contrary, total delegation is often, and unfortunately, the more common practice. I believe that one of the gauges of the community intervention's efficacy lies in being able to keep the institutional "third party" continuously informed, since it will probably be that party to whom the patient will be assigned upon release from the community.
In this regard, M. Biaggini keenly observes that, over the past decade, therapeutic community workers have had to face an increasingly obvious weakening in the clinic authority of State-run facilities, at least as regards their shared responsibility for patients in therapeutic communities. He highlights how the passive attitude of the therapeutic community team vis à vis this weakened role of the clinical Third – i.e. the patient's referrer – supports an increasingly evident attempt to appropriate management of the Third role, and he suggests a series of countermeasures that the community can adopt in order to preserve this element's function. In essence, says Biaggini, the teams working in therapeutic communities should avoid slipping into the depressive situation, along with the patients, of feeling abandoned by the Third, and strive actively to preserve the therapeutic potential of the triad. This both by actively proposing release and reintegration projects that follow up the community experience and successfully include all three subjects involved in the treatment, as well as using a communicative approach to how the course of treatment is progressing that preserves the clinical observation of the patient and thus quells overwhelming worries of an financial nature.

Mapping out a course of therapeutic community treatment. Intellect and creativity
"To course across more kindly waters now my talent's little vessel lifts her sails, leaving behind herself a sea so cruel; and what I sing will be that second kingdom in which the human soul is cleansed of sin, becoming worthy of ascent to Heaven".

Says Dante in the first canto of Purgatory on the way from Hell to Heaven.

In our case, we do not depart from Hell, the community is not Purgatory and release certainly does not open the gates of Paradise.

More simply, the question is one of identifying the instruments useful to the construction of the patient's course of treatment for that long stretch that starts when he/she enters the community and ends upon his/her release. In any case, a bit of intelligence is needed, since it is very difficult to simplify into general terms the therapeutic process that takes place in a community. A multitude of individual and group-related variables are, in turn, highly dependent upon age, personality, pathological and patient features, all of which contribute to the therapeutic process/course of treatment of a patient in a therapeutic community. It is true, however, that the community offers something specific. If, on the one hand, it has in common with other forms of therapeutic work the pillars *holding, insight and mentalisation*, and we sit down and analyse those, what interests us in particular here is what makes the therapeutic community different from other forms of treatment. Some elements can be identified.

An unavoidable one in therapeutic community treatment is responsabilization. The community is actually **a care organisation oriented toward responsabilizing patients and restoring their ability to be agents.** Indeed, we could be even more radical and say that the community aspires to become a care organisation that promotes the responsibilization of **all participants** in its undertakings: patients, caregiver staff, family, referrers, society, etc.

This sort of formula reveals all the mythical/utopian inspiration that pervades the theoretical thinking in the community, an ideological inspiration that clearly needs to be contained. It is true,

however, that this is precisely a request that must be made to everyone involved, in keeping with his/her specific role and skills, patients in particular. The community, in my opinion, must go in the opposite direction of that rigid biological passivizing psychiatric reductionism that locates disease in the genes and neurotransmitters of the ill.

In fact, it is no accident that, starting with Tom Main, two adjectives – therapeutic and democratic – from two very different domains occur side by side in descriptions of the community. In what other field of medicine could that could occur? None, obviously!

The Anglo-American model of the Democratic Therapeutic Community remains a clear example of the tendency to make of the daily routine of community life a continuing opportunity to recuperate roles and responsibility. Examples of this are the subdivision of housekeeping chores (6), participation and arrangement of staff and patient meetings or of both groups combined, and exploring the effects of our actions, emotions and thoughts on the group and, vice-versa, how the group influences our actions, emotions, thoughts and much more.

The guiding principle, I would almost say the path already marked, that every course of therapeutic treatment must follow, is precisely that of the patient's responsibilization. This being based on the idea that the origins of mental illness (and its consequences) lie in the patient's missed subjectivation, and that recovery of the ability to take responsibility encouraged by an environment dedicated specifically to "therapeutic democracy" can enlist the resources he/she still has to resume the evolutionary journey.

As I have already said, the therapeutic community should set itself up as a specific place of treatment where patients are given back their responsibilities and, conversely, a bit of their power.

This element informs every therapeutic, task-related or social activity in the community. Taking the interior/exterior metaphor once again as a "landmark" by which to map the patient's voyage, we can say that the process of responibilization goes toward relocating the ability to feel, understand, act and influence – i.e. that which has been entirely relegated to the patient's exterior – in his/her interior.

Specificity of diagnosis and pharmacological treatment in therapeutic communities

Psychiatric and psychodynamic diagnosis and psycho-pharmacological treatment take on a different form within the framework of the community, since it lays the foundations of a new kind of therapeutic alliance with the patient. (6) Indeed, the community could well be considered a place for formulating different psychiatric diagnoses. This mainly because it offers the novel opportunity to observe the patient from a multitude of perspectives, in the midst of a multifaceted routine in which he/she sleeps, eats, argues or negotiates, falls in love, etc. In this more "natural" setting – unique to the field of psychiatry and psychotherapy – the clinic is able to formulate new diagnoses regarding how the patient functions intra-psychically and interpersonally. No less important, however, is the fact that only in the community do patient and caregiver take part in the same daily routine and the same group, alternating both formal and highly informal moments. This makes it possible to identify and discuss the patient's pathological behaviours with him/her on the basis of the cogent and empirical information they share.

The psychopharmacological clinic in the community also exploits this organisational and mental arrangement, inviting patients to **become co-responsible for their psycho-pharmaceutical treatment** by sharing their feelings and sensations on the effect of drugs and discussing with the clinic how much the medicine works in the service of defence and resistance or, conversely, of liberation and insight. New evidence on the psychic workings of the mentally ill has led to a profound review of the meaning of the psycho-pharmaceutical, especially in the case of personality disorders where the dosage and complexity of prescriptions indicate more about caregiver impotence that a rational pharmacological project. It is clear that during this process the patient

must accept the idea of shouldering greater responsibility, emerge partially from under the caregiver's wing, and *stop and think for him/herself*. In more fortunate cases, the community can be viewed as a setting that facilitates the patient's **partial pharmacological de-chronicization**, especially as regards its symbolic aspects. This allows patients and caregivers to review the illness without the distortion of years scarcely effective or even useless pharmaceuticals.
This particular function of the therapeutic community, which is of especially major importance in the case of patients' resistant to treatment, is described perfectly by the Austen Riggs Center in its Community Therapy Programme's latest book. (7)

Aggressiveness in the therapeutic community. The sustainable balance between emancipation and destructiveness
At a certain point in every course of community treatment, the theme of aggressiveness arises, of which there are numerous versions. These range from the most glaring and explicit, in which anger toward the other or self-directed takes the form of serious agitation that can threaten the survival of the subjects concerned, to the thousands of transformations in which aggressiveness is masked as something else: impulsiveness more or less sexual in connotation, passive/aggressiveness, feelings of depressive guilt, altruism, sadism and masochism, complacency, bold resistance, obsessive order and its reciprocal, silence or rapid speech, slovenliness, disorderly eating habits, etc.
This is an issue of the first order, because we can state with confidence that patient's inability to utilise aggressiveness to liberate him/herself from dependence and individuate as an autonomous subject, is one of the features common to all serious pathologies.

Indeed, one of the peculiarities of the *homosapiens* species is its prolonged dependence on parental nurturing, which, although it appears to have been a winning evolutionary "choice", allowing for the transmission of the culture of one generation to another, also contains our most fragile point. We are obliged to make the long and bumpy journey toward emancipation from this profound dependence before we are able to individuate as autonomous entities.
In the process of human development, both normal and pathological, separation and individuation constitute a fundamental challenge that follows us for our entire lives, with a variety of features and in a variety of phases. The process of detaching from the original figures on which one is dependent, the gradual development of autonomous and separate functioning, the experience of one's own individual features, are all aspects peculiar to evolution, the outcome of which gives an increasingly definite sense of physical and psychic identity.
In states of serious mental illness, we can observe what happens when the process of emancipation is arrested, in all its dynamism.
Aggressiveness in the human species is a sort of "slave of two masters". If it leads to resolve, determination and strength, it provides energy that allows the subject to pursue his/her aptitudes and destiny. (8) Where this does not happen, the patient remains locked into forms of dependence on his/her own original objects, who will cause pain for his/her entire life by impeding the separation/individuation process to take their place with the passing of generations. (9)

Going back to the community, the key is to equip ourselves with a "*a clinical sensitivity that allows us to understand the patient's attempts at emancipation. These are often expressed aggressively and are unrealistic and destined to fail or to trigger new and even more profound crises; or else are authentic opportunities to be helped through a healthy emotional crisis that allows them to gain greater autonomy and a relational life based on a minimum of reciprocity*" (Zapparoli). In order to make this happen, we must be firmly convinced of the positive value of aggressiveness in seriously ill patients! Because aggressiveness can, at the same time, be a manifestation of anger against the object of dependence or its representation. It may simultaneously signal panic and terror at the prospect of change, spurring attacks on caregivers or other patients, or signal a potential emancipation capacity unable to find a healthier or more mature means of expression. The essential issue is to be timely and coordinated on symbiotic and emancipatory needs in order to distinguish

the kind of aggressiveness that leads to the death of the self from that which could lead to liberated rebirth.
Inside that little experimental society that the community represents, this kind of issue touches every person – patients and caregivers –, every activity and every moment of daily life. The community itself, as an organisation, is placed in tension by a basic contradiction: on the one hand, it wants to ensure stability and security, but on the other is able to accept that the appearance of aggressiveness within it is a residue sign of psychic vitality and autonomy: what to do?
A strictly objective, technical, "one-size-fits-all" answer would be impossible because every community has its own story, its own physiognomy, type of patients and caregivers, except that as a general rule every manifestation of individual or group aggressiveness must be queried in a direct and authentic way. Hetero-aggressive and auto-aggressive acts, escape, violation of agreements, fights, failure to acknowledge caregiver authority, often represent attacks against or forms of resistance to treatment. Other times these are primitive attempts at emancipation; immature or partial forms of authority that the subject is able to test for the first time inside the community because he/she recognises it as a safe (therapeutic) environment capable of re-signifying through reverie the emancipatory significance of those attempts.
To caregivers goes the difficult task of realising that the appearance of aggressiveness or its derivatives is part of the community therapeutic process. That it is not to be understood solely in the negative sense, and that it is not to be taken for granted that a patient who shows no form of aggressiveness is better allied that another that exasperates us with his/her continuous provocations. The community is obliged to help the patient resume that evolutionary path that has been blocked precisely by the non-emancipatory use of his/her aggressiveness.
The question becomes even more intricate in consideration of the fact that the community is a group treatment apparatus whose members develop complex social relations. It can be complicated, in this type of extended setting saturated in daily routine, to provide space for manifestations of aggressiveness because of their potential to undermine the safety and stability of the community itself. Thus, in order to ensure a properly therapeutic environment, the availability of individual treatment mechanisms is desirable, in which patients can discuss the source and significance of their aggressiveness with their own therapist. A special community meeting could be called to discuss with the other residents the effects of that aggressiveness on the others, with a view to achieving a sort of reconciliation that manages to contain and mediate all the emotional reactions the aggressiveness provokes in the group: vendetta, resentment, fear, resignation, rivalry, submission, etc.
Shifting our attention from the community to psychotherapy, we are aware that the attacks on and ruptures with the setting are often precious opportunities, and in some cases necessary ones, for therapy to take its course. They are, at the same time, moments in which authenticity and spontaneity are able to emerge – as demonstrated by the Chicago school's theory of "now moments". Moments in which aggressiveness, in all its various guises, makes its appearance in the community must be examined on both individual and group planes. While, on the one hand, this fact constitutes an element of complexity, on the other it renders the community a very powerful instrument, capable of intercepting evolutionary potential in even the most disturbed patients. An excellent example of this is the aforementioned Austen Riggs Community, a highly complex and interdependent treatment organisation within which psychopathology is analysed by a variety of experts and by means of a variety of therapeutic tools.

Groupality in the therapeutic community: A free choice?
A final element that, in reality, is interwoven in all my preceding reflections: Community treatment is inevitably a group undertaking. During this period of co-habitation, very deep relationships develop among the patients and staff, and sometimes even among family members and other subjects participating indirectly. This sets the community apart as a healthcare organisation. Starting with intake, a painful moment of detachment from previous living conditions, the patient enters a specific dimension of long-term treatment that offers the possibility of fully revealing his/her true

nature, and of sharing a daily routine with the other patients and the caregivers. It is, above all, the group dimension of the community that offers new opportunities. Indeed, with serious pathology, the individual patient/therapist relationship at times turns out to be as ineffective (or pathological) as the individual parent/child one was. In other words, community treatment is thought to be **the most suitable for intercepting the groupality intrinsic to every individual by avoiding his/her personality and pathology being relegated to the individual plane**. The therapeutic community should be structured as an "open and free rehabilitative setting" that allows patients to experiment with different roles, gradually recuperating or acquiring that minimum of control over themselves that is necessary for any existential enquiry. Here lies, I would repeat, one of the problems with regard to which the talent of a particular community can be measured: the ability to construct as open a rehabilitative setting as possible, in keeping with the needs for stability, safety and legality that all institutions require.
For some subjects the reduction of freedom that co-habitation involves can be an unacceptable limitation, while for others the feeling of security in finally belonging to a community assuages painful feelings of solitude and separation from the world, which is, by its very nature, a therapeutic factor. It is true that some personality organisations, such as those of narcissistic and obsessive patients, are especially hostile to adapting to community life, since they have difficulty tolerating the limitation or renegotiation of their personal freedom. Perhaps the failure or interruption of some courses of treatment can be attributed to the underestimation of this element in the initial intake phase.

Concluding thoughts

I have attempted to focus on some of the specificities of designing a course of therapeutic treatment in a community setting. In doing so, I have realised that it depends, above all, on the general conditions placed at the disposal of the community group apparatus, and that make this treatment different from others and capable, at times, of overcoming the resistance of the most difficult patients.
The interior/exterior dialectic used as a landmark in the construction and conduction of the course of treatment in a community is a valid instrument. First and foremost, in order to create a therapeutic container that allows patients to feel adequately "contained", and thus that they have acquired a "residence". A point of departure from which to better understand what in their lives comes from outside, thanks to the urging of the caregivers and of their initial social experiences, and what, instead, comes from their psychic interior. This is where they start to re-appropriate their destinies by re-integrating a bit of responsibility and power.
It is also a useful instrument for recognising that aggressiveness can have an emancipatory function if the patient learns to keep a part of it inside and transforms it into strength and determination, while the opposite reaction both drains the patient and, at the same time, damages his/her social relations. The former case taps the energy needed to unravel the knot (interior) of relations with him/her self and of (exterior) relations with the others, while forsaking the empty promises of omnipotence.

The therapeutic community is rather an eccentric place compared with the dominant dogma of our social discourse.
Its bottom line is a social idea based more on cooperation than competition. Perhaps it is no accident that the idea grew out of the tragic results of the Second World War; or that it is having more and more difficulty finding convinced support and funding today, given the current society's orientation toward the pursuit of individual success and performance.

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Note

1) A "landmark" in maritime jargon is an easily recognisable point along the coast (exterior), such as a lighthouse, a promontory or a bell tower, marked on a nautical map (interior). A calculation involving the landmark's height and its projection on the nautical map makes it possible to pinpoint the vessel's position at sea. Navigation has been done that way since the days of Christopher Columbus. Our dependence today on acritical means of satellite navigation has deprived us of this maritime skill, now purely technological, and has even led to embarrassing and easily avoidable accidents.
2) This statement could be confusing at first, calling to mind the "thick" walls and doors of a hospital psychiatric ward as compared to those of a community fully and intentionally inserted into an urban and social context. It is enough, however, to weigh the brief duration of a hospital stay against community residence, or the frequency of disappointment at the discovery of laxer hospital rules as compared with those of the community, to realise the importance of the physical and symbolic separation from the home environment to live in a community according to its rules. Moreover, it is obvious that a hospital ward dedicated to the treatment of serious disorders at their onset, does not demand a clear "separation" between interior and exterior (e.g. during the period of hospitalisation, it is a common practice for family to visit on a daily basis) and is limited to monitoring transit and regulations. The therapeutic community is something quite different.
3) A certain amount of family member ambivalence toward the community treatment programme is to be expected, and is inevitable. On the one hand, because while the family wish the patient/loved one well, while on the other hand challenging the caregiver team in the unconscious hopes of the project's failure, and their consequent confirmation as the sole owners of his/her psychic well being. The family's "good" reception by the CT can reduce this risk considerably.

4) Continuing to "play" with the interior/exterior dialectic, we could define the community as a treatment organisation intended to re-signify the interior/exterior relationship in less pathological ways.

5) As a treatment organisation, the community always finds itself operating from what I call the "perspective of the lifeguard" who, in order to save the bather, must not only be an able swimmer but also capable of remaining afloat and swimming while the victim's anxious flailing endangers both their lives.

6) In my precise opinion, some Italian communities include the figure of the 'governor' or 'governess', a word that indicates the specific function of those who have the responsibility for or broad view of the needs of the house and its components and who governs those needs.

7) "L'alleanza terapeutica: dalla diagnosi al trattamento" see bibliography.

8) "In our approach to psychodynamic psychopharmacology, recognition and respect for patient **authority** is of fundamental importance" … he or she, "who may be struggling with significantly disordered biology, is understood to have a subjectivity that interacts with the biological substrate and is seen as having internal resources that can be recruited to address problems. The patient is not a passive battleground between the doctor and the disease. Instead, he or she is an important ally, or adversary, and the outcome of pharmacological treatment depends largely upon recognizing and using this stance". D.Mintz, B.Belnap in *Resistenza al trattamento e autorità del paziente,* Il Porto -Ananke 2015.

(9) Cfr. Bollas C. "Forze del destino"

(10) This writer is also convinced that the ability to distinguish between constructive and destructive forms of human aggressiveness, to facilitate the former and stem the latter, is one of the most complex and controversial that any culture has ever attempted to resolve on social, political and economic levels. At the end of WWII, Winnicott was already writing "*I would like to suggest that healthy economics aknowledges the existence and value (as well as danger!) of personal and collective Greed, and try to harness it"*. It is quite annoying to note, despite the many years that have passed, that such a proposal is still so topical!

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