Community therapy.  
Focusing on the foreign body.  
Effects on patients and caregivers  
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Abstract
Therapeutic communities are now and have for several decades been used for a wide array of disorders that range from substance abuse to personality disorders, and from subacute to chronic psychosis. These disorders are often intertwined and causes an overly dense diagnostic framework. It is possible to observe two different perspectives which converge into the therapeutic community system and allow us to pinpoint two pivotal factors of treatment. The first one, which we could define as individual, privileges the protective and facilitating function of the setting, which tends to be seen as a third element, between patient and caregiver, and therefore such that it can permit a one-to-one relationship that would otherwise be made difficult by the intensity of the transference. From another standpoint (1), however, collective and group factors must be stressed, insisting on the overall therapeutic value of the community setting, understood not only as humane but also as a cultural mechanism capable of offering an affective but, so to speak, structured and orderly, reception. From this second perspective, we could say, to put it very simply, that “it is the group that treats”; while from the individual perspective, it could be said that “the therapist treats with the help of the group”.

Having in mind these two clinical work perspectives in the therapeutic community, the author analyses in depth the issue of “foreign body”, definable as “a traumatic identification with the mind and body of another with which there has been a highly involving and meaningful relationship, and which includes repeated traumatic features to a more or less heightened extent”.

The community should set itself the goal of driving a sort of wedge between the foreign body and the patient-subject in such a way that the two are able to launch a dialogue, a dialectic and stop ignoring each other through destructive dissociation.

Keywords: therapeutic community, individual, group-related, foreign body, trauma, identification, therapeutic team

1. The therapeutic community, between individual and group
Therapeutic communities are now and have for several decades been used for a wide array of disorders that range from substance abuse to personality disorders, and from subacute to chronic psychosis (Ferruta, Foresti, Vigorelli 2012, Corino, Sassolas 2010). As disorders are often intertwined, what tends to be an overly dense diagnostic framework can hamper the simple identification of how the community generates its therapeutic effects.

On the one hand, we have the predominantly intra-subjective effect of the community setting: The community is considered a means for providing an individual psychotherapy that would otherwise be too difficult and frightening for both the patient and the therapist. Foregrounded from this perspective is the relationship with the caregiver of reference, in which the major importance of a closer and more intimate relationship with an individual caregiver is underscored, and the relationship with the psychotherapist, at times even external to the community.(2)

This perspective, which we could define as individual, privileges the protective and facilitating function of the setting, which tends to be seen as a third element, between patient and caregiver, and therefore such that it can permit a one-to-one relationship that would otherwise be made difficult by the intensity of the transference (Plakun 2015).

From the point of view of the centrality of individual psychotherapy therefore, particular importance is assumed by the relationship between staff and caregiver of reference and between
staff and psychotherapist, as well as the group relations between patients, viewed as intent on facilitating or obstructing the construction of a meaningful individual relationship.

From another standpoint (3), however, collective and group factors must be stressed. These include distancing from conflictual or non-existent family settings, attention to more humane and fair rules of coexistence, the value of the other and the need to build a harmonious and orderly space-time continuum (Lombardo 2007). In brief, the group perspective insists on the overall therapeutic value of the community setting, understood not only as humane but also as a cultural mechanism capable of offering an affective but, so to speak, structured and orderly, reception (Vigorelli 2005).

From this second perspective, we could say, to put it very simply, that “it is the group that treats”; while from the individual perspective, it could be said that “the therapist treats with the help of the group”. There are, of course, many intermediary ways, in which collective and individual factors are mixed to varying degrees, thus making use of a vast range of possible situations that, nevertheless, tend to rely on two polarities, which we could define as prevalently group-related and prevalently individual (4).

The situation we are discussing, therefore, lends itself, on the one hand, to providing a very rich framework, but on the other a dimension of uncertainty and a sort of vagueness, leaving open the question of “how to treat the therapeutic community”. Indeed, the overabundance of responses makes it hard to know if there is any specific factor or any, so-to-speak, “essential” element or point of departure from which to trigger a process of change.

The failure to identify this essential element, this basic factor, reappears in relation to two very important and delicate factors: the time factor and the factor of caregiver counter-transference. Indeed we are all aware that, while there is a tendency to prescribe the duration of community care (Italian legislation refers to from 18 to 24 months), there is also a tendency to extend it, especially in cases of psychosis or serious personality disorder. Could it not be that, apart from important organisational reasons, this tendency is also owed to the difficulty in identifying whether therapy has been successful and how? Has it been possible to understand, regardless of demonstrated behaviour, if something has changed in the patient’s inner world, and how that has happened? Such assessment remains very difficult in the absence of a diagnostic, non-psychiatric but rather psychodynamic element that makes it possible to discern a pathway that follows the roadsigns and milestones along the way.

The other factor that reflects this uncertainty concerns the subjective life of caregivers or, if we want to use a somewhat overly graphic term, their counter-transference. The unavailability of a more precise assessment element means that community workers nearly always experience a sense of uncertainty, vagueness and, at times, either mild or intense confusion about what they are actually doing and whether their patient is truly changing. This difficulty in assessing is often experienced as their own inability or difficulty, lack of resources or the belief that they are faced with a nearly impossible task. This “depressive” risk is accentuated by the fact that community life puts every member into a pervasive and permanent daily existence that tends to eliminate distances and renders less visible the inner world of the patient, who needs a certain controlled detachment in order to focus.

The theme of “repetition compulsion” to which Freud frequently refers in his writings from 1909 on (see Laplanche J., Pontalis J.B. 1973 ), i.e. a repeated return to rigid and instinctive ways, tends to take into consideration the sense of frustration and almost “uselessness” of the therapist, who can experience all this as his/her own inadequacy. Added to this is the risk of their using the experience of profound extraneousness to the emotional life of the patient or the group as a defence, or of accentuating aspects of their own emotional lives at the expense of the others (anger, isolation, certain types of transgressive, sexual or dependent acting out) (Plakun, 2015).

Other authors have underscored the intolerability of depressive experiences in the community, an unbearableness that is then added to that certain intolerance for depression that tends to appear in all groups (Vigorelli, 2005). Hence the relatively frequent fact that such depression is elaborated
through projection by assigning shortcomings (we could perhaps even say “blame”) to colleagues and external factors.

There is no doubt that, like every other group, communities are suffering in these historic times from a lack of economic, human and organisational resources. Likewise, there is no doubt that there are human factors within communities that render relations and collaboration difficult. Nevertheless, added to all this must be the tendency to transform the basic assumption (to use the terminology of Bion) of dependency into a basic fight-flight assumption as a way of escaping doubt and uncertainty (Bion, 1961). Indeed, I have often noted that squabbling amongst caregivers, the interminable debate over the best way to handle, for example, the over-dependency, transgression tendencies or sexual intemperance of certain patients, is directly proportionate not only to the caregivers’ feelings of inadequacy, but also to the lack of more precise criteria in identifying a possible route to follow.

It should be added that the community leadership is not always capable of blocking this process that we have called escape from depression through bickering and the projection of persecutory aspects (Correale, Pedriali, 2007). Indeed, in the community as well, leadership also suffers from excessive immersion in the daily routine: eating together, going out together, cooking together, the reciprocal familiarity in speech, making plans together, celebrating holidays, going to the seaside in the summer, swimming and sunbathing together.

This massive emersion in daily life cannot but generate a sort of familiarisation and rigidity of roles not only on the part of the patients, but staff and leadership are also unable to entirely escape it. It should be added that, at times, the community leader takes on various functions, especially in the case of a charismatic leader incapable of delegating. He/she is founder, administrator, scientific coordinator, clinical supervisor, therapist and essential member of the therapeutic team. Community caregivers’ affective investment is thus heavily condensed as regards their relationship with the leader, and this does not always facilitate identification of a possible therapeutic course of treatment. It is inevitable that this overly “dense” situation will lead to clashes, jealousies, over-attachment and painful confrontation, and the result of all this is a tendency toward excessive diagnostic and therapeutic simplification in order to get free of an oppressive sense of burden and confusing anger.

Going back to the main point, which is the aim to identify a central element, a common thread capable of linking that which happens within the patient with that which happens in the caregiving team (Correale, 1994, 1995). Specifically, what we propose is to identify a sort of “node”, a switching mechanism that works to provide through-passage from patient to other so as to identify the effects of the course of action the caregiver team chooses and, finally, how the team’s attitude can facilitate or obstruct it.

Identification of this common “node” at individual and group level is the fruit of an extended experience of consultation and discussion of clinical cases within various communities in Italy, in particular in Turin and Rome (Correale, 1993, 1998). Indeed, what remains striking now in retrospect, regarding the evolution, successes and failures of the cases discussed, is that, beyond the marked differences in psychiatric diagnoses, there is a certain constancy and uniformity to situations. This seems to indicate what we could define, in the end, as a route common to many and even highly dissimilar clinical situations. Indeed, the day of consultation lends itself to forging moments of synthesis, in which the inevitable inclination for fragmentation and detail condenses into a relatively constant and stable form. Focusing on these forms is common to all the individual diagnoses and supplies a meaningful element for deciding on a possible route to change.

I would therefore like to say that a possible, and not too rigid – but neither overly broad nor generic – definition of this form could be the following. Without exception, all patients whose cases are brought to clinical discussion feel they are the victims of a type of “foreign body” that they feel has taken up residence in them and persecutes them, but with which they also partially identify. This foreign body initially presents itself as an experience, which sometimes takes over and becomes
increasingly like a form of clothing they are unable to take off; an inner person that dominates them, and finally a nearly total identification with a sole part that drags them almost outside themselves into another self, both foreign and familiar. This theme of the foreign body is common to many psychic conditions, although with significant differences, and, in particular, to certain cases of psychosis and serious personality disorders – disorders in which trauma plays a decisive role. The often-present use of substances is nearly always a secondary factor whose main purpose is to render “coexistence” with this foreign body tolerable. The time has come to examine this concept more deeply.

2. The foreign body

In order to take a more detailed look at what I have chosen to call the “foreign body”, it would be useful to begin with the theme of trauma. Nevertheless, it would not be appropriate here to address the extremely broad and continually expanding theme of trauma in current psychiatry and psychoanalysis, in which the link between traumatic experience and personality disorder is subject to increasing discussion (Williams 2009, Mucci 2015).

Instead, I would like here to talk about trauma solely to the extent to which it lends itself to better understanding our assumption. In necessarily limiting the discussion of trauma to a series of basic aspects that are indispensable presuppositions to what I wish to describe, we can say that specific to the traumatic experience is the sudden triggering of a very intense emotion in a person partially or entirely unprepared to handle it. The partial or total lack of warning plays a fundamental role in this situation (Freud, 1920). The triggering of this emotion generates a mix of subjective terror and excitement (Freud, 1920). The terror is associated with anxiety about passiveness, exposure to a predominant and uncontrollable force that the subject feels entirely under the sway of. This painful passiveness exposes the subject to illusions or real expectations of death and, in any case, to transformation into something inhuman, formless and defenceless. But the other element – excitement – is equally difficult to tolerate, triggering a destructive impulse that has something powerful and, at the same time, attractive about it, and that concerns the illusion of simultaneously attacking oneself, the dangerous other and the entire world, in a sort of undifferentiated and constant rage. The subject simultaneously loses him/herself and becomes an inanimate and primordial object, a sort of anonymous and indestructible force. The subject reacts to that illusion with a mixture of fear and attraction that confuses and disorients (Correale 2010, Mucci 2015).

This entire sequence of events, at times marked by terror and passiveness, at others by excitement and tension, is accompanied by a profoundly changed mental state. The term dissociation is commonly used nowadays to describe a modification in the state of consciousness in which a vertical fracture in the subject has taken place. A part of the subject acts mechanically on his/her behalf in an automatism based on a more or less accentuated sense of unreality. The other observant part can experience more or less total obliteration. The repetition that inevitably follows as an unavoidable effect of trauma, and constitutes an attempt to dominate both the dread of death and the excitement, does not adequately perform either of those tasks. Instead, it reveals that dark and violent pleasure of attempting to navigate the destructive avalanche that finally frees us from beneath the burden of suffering. This also goes for relational traumas, i.e. those associated with situations of deep affective involvement with another person, nearly always within the context of an oedipal or love relationship.

In these cases, another factor is added to the traumatic experience, which turns out to be decisive in the cases we are discussing, i.e. therapeutic community patients affected by trauma-based personality disorders. Indeed, in these cases dissociation leads to a partial or total identification with the traumatizing other, or to a complementary identification with a personality that continually confronts the traumatizing other (Correale 2010). We speak, in such cases, of alienating dissociation (Ruggero, 2012), and of traumatic identification. The result, in any case, concerns the fact that the
subject “becomes”, so to speak, another person, concealing or obliterating the more authentic and vital basic subjectivity, and acquires a mask, which it does not experience as a mask but as a new self.

This identification has the significant advantage of restoring a momentary, apparent lucidity to the traumatized mind. In trauma, in fact, as I said earlier, the emotional experience largely diminishes superior cognitive ability, replacing it with emotional waves – rage, terror, excitement – and sensory triggers similar to those of dreams, in which a flood of apparently disconnected sensory details displaces superior activity (Meares, 2000).

In this context – which truly deserves the term dissociation in the most literal sense, as opposed to that which, in my opinion, has become an overly broad application of the word – identification constitutes the only possible way out. *If I become another, I can convince myself that I am in control of events and even steer them. In any case, I have a way to channel my emotions, which are now “managed” by the other person that I have become and no longer by my original self.*

In traditional psychoanalysis, it is common to use the term “incorporations” to describe identification with primitive, manipulative features where there has been no separation between the subject and the other before the phase of identification, toward an original confusion that leaves almost no room for conflict between the two parties in question: the base subject and the subject identified with the traumatizing other.

An important problem arises that, however, we will not address here.

Not all incorporations are traumatic in origin. Many cases of this sort are merely conflictual and experienced by the subject as a confrontation between parts. But all contain a relationship with the other in which the other’s invasiveness is extreme and to a certain extent unbearable. Bion described this type of situation in his famous “Imaginary Twin” (Bion, 1958), in which he speaks of a subject in which an anti-libidinal superego has taken over the total personality and inhibits not only the ability to feel pleasure, but even the subject’s sensory functions (sight and hearing in particular).

It is not possible to speak of dissociation in such cases, which must be distinguished from those traumatic. Indeed, in traumatic cases, the appearance of the acquired personality is more violent and extreme, with traces of automatism, and is accompanied by more or less intense experiences of depersonalisation.

In the case of the imaginary twin, we are witness not so much to a depersonalisation as to a dark and monstrous self-rejection, less categorical and less marked by the rhythmic shift into and out of the identificatory personality. The traumatic or alienating identification, moreover, brings with it a partial or total loss of the subject’s corporeality. The body is used as if it were that of the other and its sensory functions are altered since they have, so to speak, been lent to the acquired personality. This state of body no longer owned but lent to another is experienced with dark pleasure because it creates the notion of, in any case, being connected to a significant other who offers strength in exchange for absolute devotion.

We are now at a good point for going back to the theme of the foreign body.

We could define as a foreign body a traumatic identification with the mind and body of another with which there has been a highly involving and meaningful relationship, and which includes repeated traumatic features to a more or less heightened extent. This situation – *someone lives inside of me, but I do not rebel against this colonisation because it gives me strength in the difficult, traumatic moments that life inevitably presents* – can be defined in a more literary than scientific way, as a “pact with the devil”, possession by a demon.

The relationship with the foreign body can therefore be activated almost automatically any time the subject is unable to handle an experience similar to trauma, or when that relationship is so pervasive as to occupy a permanent place within the personality.
For therapeutic purposes, the most important element concerns another two points.
The first foregrounds the question of time. When does the “devil” appear and why, and how long
does this presence last? Why does the “devil” appear in some moments and not in others? What
sorts of frustrations are able to trigger this very dangerous process?
The second regards degree of awareness. How aware is the subject of being colonised, and how
capable is he/she of keeping it at bay? It is possible that the subject experiences the foreign body as
a torment, a threat, a form of anxiety, or as a resource, a chance to escape the mortal passiveness of
the traumatic experience. That is precisely where therapy must find its way in: in this chance space
between passivized relationships (real but devoid of resources) and traumatic, energising but
destructive, repetitive and automatic identification.

The experience of community discussion of clinical cases has confirmed that in all cases of
personality disorder of traumatic origin, the foreign body becomes predominant and constant. In
cases closer to neurosis, it is more concealed and pervasive, apparently less visible but experienced
in a more conflictual way. In cases closer to outright personality disorder (borderline, anti-social,
malicious narcissistic), it is more visible and experienced without conflict, but rather accepted as
inevitable.

I hope to have demonstrated, albeit in this extremely rapid and abbreviated manner, that the theme
of trauma invariably flows into that of the foreign body, understood as the installation of an other
who comes to the aid of the subject whenever trauma threatens, and that gives the subject life in
exchange for handing over his/her true personality. By true, I mean the experience of one’s body as
exclusively one’s own, to which relations with others always add something but cannot entirely
replace.

A brief mention of psychosis.
If by psychosis we mean a terrifying accentuation of certain sensory experiences (internal, in cases
of psychotic hypochondria, or external, as in cases of persecutory, mystical or erotic anxieties), we
can describe delirium as an attempt at explaining and familiarising these sensory experiences
(Correale, 2016).

Unfortunately, however, delirium is not enough. It is typical for the psychotic to feel something
uncontrollable happening within. It is as if something were coming from within that is internal but
that comes from outside by way of the internal. It is this experience that gives psychosis that sense
of detachment, on the one hand, and certainty on the other. Surely something I cannot control is
happening inside me, making me construct bizarre explanations for it in order to accept it. But,
since delirium is never enough to counterbalance that state, psychotics are frequently attached to a
figure – often loved/hated but protective – whose presence helps to keep that growing inner feeling
of detachment at bay.

In this way, the psychotic experiences a dual identification, with the delirious personality and with
the protective person, whose function is to offset the psychotic anguish. In both cases, the foreign
body takes possession of the subject, although in ways that differ from cases of personality disorder,
where dissociation prevails. Here, on the other hand, what dominates is a hallucinatory mental
process that can lead to hallucination and delirium but whose management must, in any case, be
through a total and undifferentiated relationship with the protective other.

Substances, in this context, acquire the function of erasing both the original, obliterated subject
and the secondary or foreign acquired subject. In other words, substances serve to annul the foreign
body (sedative ones) or to accentuate some aspects (stimulants) (Correale, Cangiotti, Zoppi, 2013).
Other cases involve the foreign body’s mystical/omnipotent approach, by which it makes peace
with everyone in an apocalyptic presentification of a sort of universal harmony in which death is
both a rebellion and a reconciliation of all oppositions. Some suicides that take place within
communities have this nature of angelic salvation through the destruction of the self, which,
however, assumes the nature of redemption of the self and of the entire world.
### 3. The work of the community and the foreign body

We can now go on to the community. How does it confront this theme? Can it be said that the community’s main task is to introduce awareness of this foreign presence in its host? How does this awareness raising take place, and does the caregiver group facilitate or impede the process?

What has been said thus far leads inevitably to the project that this effort offers the community. The community should set itself the goal of driving a sort of wedge between the foreign body and the patient-subject in such a way that the two are able to launch a dialogue, a dialectic and stop ignoring each other through destructive dissociation.

To that end, I would essentially like to focus on three points:

- the positive effect that the group/community has on patients by grounding and distancing them from the original setting;
- the positive effect of being surrounded by figures, patients and caregivers, who become true personifications of the patient’s world; and
- finally, the thousands of minor or major daily traumas that can serve to trigger recognisable imaginary and behavioural patterns.

Regarding the first point, it is important to recall what all the literature on groups has repeatedly underscored. Groups are large apparatuses amply capable of effecting the partial or total depersonalisation of those who join it (Neri 1995, Correale, Parisi 1979). The multitude of participants, accentuation of perceptual and sensory data (bodies, voices, physicality), emotions of the others and the activation of primal fantasies (mouth, body, primal scene, invasion, seduction) (Anzieu 1976, Kaës 1976) – all this, so to speak, “heightening” of physical and mental experience, erases the subject’s original contours, at least at the start, and forces him/her to accept a new and less recognisable one. Patients can experience this as a form of depersonalisation to the extent that they feel a certain extraneousness replace their usual way of being.

Added to this is what I propose to call, in a positive sense, “grief” at having entering the community (Correale, Neri 1975). Joining the community, in fact, means drastically breaking with one’s previous life, accepting the diagnosis of significant disorder and facing the fact that it is going to take at least several months to initiate change. It also means accepting a new daily routine, new persons deciding for you, and confronting the risk of feeling like a stranger among strangers.

This duality – the depersonalisation that goes with joining any group, and the underlying grief for having joined it – makes that entry serve as a shock, a fracture, a major rupture in the continuity of life, a separation between before and after. At this point, it should be added that the time spent in the community will remain a persistent memory in the subject’s life, both in his/her eyes and those of the others, and can be experienced as a failure or a success. I believe that this initial fracture is a powerful therapeutic tool for introducing a separation not only between before and after but, and principally, between the person and his/herself. The subject has to deal with an unknown setting that not only distances him/her from the rigid preconceptions of previous life but also encourages him/her to try unfamiliar ways of relating. Such a situation inevitably triggers major anxieties. These can be depressive anxieties (I have lost my previous life, I no longer recognise myself; I’m seriously ill), persecution anxieties (what are they going to do to me, what do they want from me), and loss anxieties (where have I ended up, I’m in a foreign place, we don’t speak the same language).

These anxieties can have two outcomes.

The first, a positive one, is that the questions the subject begins to ask about the adequacy of his/her basic identifications, about his/her “foreign body”, can be confronted in this new emergency. The situation can trigger a sort of “good dependency” on caregivers, who can be experienced as guides and supporters in this dangerous and unpredictable transition.

The second possible outcome is more negative. Defences against these anxieties can cause the subject to cling more tenaciously to previous preconceptions leading to the activation of set, family-style roles understood as a form of protection from the newness of community life.
In brief, on the one hand a positive embracing of loss and, on the other, an accentuation of familial roles, a sort of familiarisation of the setting (Baglivo). The projective identification model is useful to indicate the way in which these roles are injected, so to speak, into the caregivers, who can respond in a way that is either passive and conciliatory or more aware and critical. It is here that the first question arises. The community risks undergoing this familiarisation, this subdivision into set roles, and can perpetuate in daily life that division that has dominated the previous context (Plakun 2015). An excessive and literal repetition of the rules can, in this sense, be an element of major importance. It is the rules that underpin the new situation and therefore they must be pronounced. New rules break with old models and pave the way to new ways of feeling and behaving. Indeed, a rule must be presented as just that, and not as the reconstitution of a rigid and unquestionable law. In other words, the rule can either stand for an old super ego that is already far too entrenched in the patient, or a new ego and carrier of new experiences. How to strike the right balance? I believe that one possibility is to accept the profound ambivalence that the patient feels toward the community not as destructive aggressiveness or manipulation but as a weak defence against loss of orientation. For example, an overly dependent or possessive and needy patient can be helped to think of his/her dependence as a foreign body to which he/she turns when afraid of the newness of his/her feelings, such as body function, bonds of friendship, non-violent sexuality, and so forth. In other words, that ambivalence should be evoked continuously, never excluded or presented as a struggle between old and new and only as aggressive. Aggressive sexual behaviour can, therefore, be viewed as a defence against affection; excessive dependency as a defence against mistrust of the relationship; excessive laziness as a cover for feelings of guilt about one’s own body and sexuality. The question should always be: Why does the subject always resort to the foreign body? What is he/she hiding? What does he/she want to avoid? How can patients be helped to discover that part of themselves that they never show, not even to themselves? Conceptualisation of the foreign body, i.e. of alienating and defensive identifications can help.

4. Pedagogical hypertrophy and contagion anxiety
As stated earlier, such questions must not arise in a caregiver attitude that under-values the function and utility of rules in order to take refuge in a priori interpretative positions. What I have in mind instead is the need to study and maintain a balance between, on the one hand, the recourse to the rules as an element that breaks with old categories and introduces new ways of feeling and behaving and, on the other, the continuing study of meaning, starting from a psychodynamic view of the problems treated. This is surely a question of two different attitudes or styles adopted by therapeutic communities when treating patients, and which are based on separate over-arching principles that we could define as the pedagogic and the psychodynamic.

Whether one modality or conducting style predominates is, to a certain extent, regardless of the specific way in which time and activities are arranged. Many communities provide space for group psychotherapy, individual psychotherapy and analytic psychodrama. Yet the style in which the group is conducted remains essentially educational/pedagogical. In other communities, attention centres on what could be considered formative – how to follow the rules, take on responsibility, and dialectically discuss ideas – without psychotherapeutic structuring. Nevertheless, a style of conducting that allows for individual rapport and certain interpretations of content and of transference are discernible in-between the folds of the activities. It is therefore necessary to better define the concept of conducting style. By this term, I mean a particular way of addressing patients, a manner of speaking, a type of language that introduces an atmosphere, a way of feeling that more or less consciously permeates the entire mental and emotional workings of the group as a whole, both patients and caregivers.
Various features are activated when the pedagogic/educational polarity prevails, which it is possible to list.

First of all, the group as a whole has an advantage, while the individual relationship between patient and caregiver is much less and, in some cases, never, foregrounded. In some communities, one caregiver is assigned to each individual patient, while in others the task of analysing and discussing problems and difficulties affecting the lives of the individuals and the group is left to the group as a whole.

Secondly, the rules are fundamental. Schedules, chores, leave, the use of tobacco, television, free time, are subject to very precise rules, and breaking those rules is often considered a sign of aggressiveness with borderline features. Sometimes, in highly disciplinary communities, requests for special attention are discouraged. The patient who needs an extra listen, and who tends to engage a worker or caregiver in privileged relations, is considered a “manipulator” and demanding, and is reminded of the principle of distributive justice.

We could say that active behind the pedagogical/educational polarity is the idea that it is necessary to build an ego ideal in every patient that acts as a stabiliser or balancer for excessively libidinal or destructive instances.

On the other hand, when the dynamic polarity prevails, the predominant factor is the personal relationship. The caregiver/patient working relationship is considered the main reason for therapy, and the workings of the group are aimed at boosting and facilitating this relationship by sustaining both patient and caregiver in the difficult task of maintaining their demanding relationship over time.

Moreover, when the psychodynamic polarity prevails, the entire group and its events are the object (at least this is the intention) of dynamic and interpretative monitoring. Nothing must be lost, no event pass uncommented, because each is potentially an open window on the patient’s unconscious and on how it creates transference.

The thesis that I would like to advance in this paper is that these polarities are both inevitable and necessary.

Communities overly inclined toward the pedagogical style tend inevitably to compartmentalise, with patients being assessed on what they do rather than what they feel or experience or dream. Behaviours are either approved or repressed, running the risk of mental health being evaluated solely on the patient’s ability to adapt to the environment.

Communities with an exclusively psychodynamic polarity run the risk of confusing roles and positions, excessive intellectualising psychologism, and of building reciprocally hostile subgroups within the larger group whose confrontations tend to create a leadership vacuum.

It is therefore necessary that the two polarities be interwoven, nevertheless keeping in mind the antagonism, competitiveness and, in some cases, irreconcilability between them. Such antagonism can be structured around two separate caregiver subgroups, each of which espouses one or the other polarity. This phenomenon can lead to group paralysis, aggressiveness, depression and inhibition in the caregivers and, at times, even in the patients.

The phenomenon is accentuated when the community leadership lacks the sufficient energy or necessary lucidity to recognise that this is the type of conflict that needs to be identified. If this does not happen, the conflict shifts to the personal level, leading to loves and hates, sympathies and antipathies among caregivers, the results of which are unpredictable.

Useful in formulating that very difficult synthesis that we have indicated as the principal aim of life in the community, and the essential task of its leadership, is a certain type of targeted attention.

I mean to say, and this is the central thesis of this article, that it is necessary to be acutely aware, at every moment of community life, of any excessive shift from one polarity to the other. If this shift does take place, and often, it is essential that those of the community pay close attention to the events or situations that trigger it.
In the absence of such attention, the shift will take place involuntarily, resulting in the accentuation of the features typical of that polarity and the consequent inevitable obstinacies. At this point it is possible to identify a pattern that I have encountered repeatedly in supervision sessions and that consists of accentuating the pedagogical/educational polarity. Several characteristic phenomena are noticeable when this shift takes place. First of all, the rules acquire inflated value, and run the risk of being presented to the patients not as ways to show respect for others, but as inviolable laws laid down by a power that must not and cannot be questioned. A scholastic, dogmatic tone appears that, while necessary in many cases to curb impulsiveness and lack of control, can inadvertently seem assertive and intolerant. There is also the risk of viewing the patient as merely someone displaying behaviour rather than someone having an experience, responding to deeds with deeds but also with words and explanations. The phantom underlying these phenomena is certainly that of the infantilised patient prey to wild, aggressive feelings. This phantom, in some cases justified, becomes dangerous when it extends indiscriminately to all the types of problems shared by the patients. I would posit that this, which I would like to call a sort of infantilising degeneration of the community (or, if you like, the attraction to a basic fight/flight assumption in reaction to the good or bad infantile aspects of the patients), always happens when a phantom of violence or death appears in the community. Indeed, episodes of physical or verbal violence often occur in communities; in other cases, in the absence of violence, the fear of death localised in one patient generates defensive behaviours such as excessive dependency or tendency toward isolation. The thesis I would like to maintain is that the phantoms of violence and of death are spread secretly among the group, caregivers and patients alike, leading to group defensiveness. But the observer, or the group itself, can be so deeply affected by this defensiveness as to lose sight of the phantom of violence or death that has generated it. I would like to offer two examples from literature that seem to me appropriate in illustrating this fundamental point and central thesis of our discourse. The first concerns violence, and brings to mind Peter Weiss’ Marat-Sade. The setting is a psychiatric hospital; Marat is soaking in a bathtub for the treatment of a serious skin disease, and is killed by a young revolutionary named Carlotta Corday. Underlying this frightening scene is the theme of a weak person killing a strong one caught at a moment of weakness (Marat is a great leader, but is ill and in need of continuous baths). The scene is so pregnant and dramatic that the group of psychiatric patients in the hospital rebels against the doctors and nurses and starts a revolution. In the end, the patients become the caregivers and vice versa. It seems to me that this scenario, on the one hand, strongly embodies the origins of violence (a daughter becoming violent against a violent father) but, on the other, the contagiousness of such a scene and the consequences of this contagion on the entire hospital group. Numerous examples can be cited of violence in the community setting, which raises fear of contagion in those present, accompanied by the terrifying fantasy of role-reversal. If this phenomenon occurs unconsciously, the community will over-accentuate the educational/pedagogical components, with the consequent risk of infantilising patients, for the purpose of responding to the threat by amplifying the power function. An alternative would be to identify the aggressive event, contain it within the confines of transference and, finally, extend it to the group to allow for its partial attenuation. It is my belief that, in many cases, violence within the community setting is an expression of a caregiver-patient transference that has not been elaborated. In the absence of such elaboration, the emotions not contained within the pair relationship will spread out to the group, resulting in the effects mentioned above.
The larger group then has the task, to the extent that it is able, of reining in the violent episode and discussing as many as possible of its unexplored aspects. Something similar takes place in the case of death anxiety, with regard to which I would cite Conrad’s *The Nigger of the Narcissus*.

In the story, a man suffering from tuberculosis – either dying or faking it – is hired as one of a ship’s crew. The rest of the crew, paralysed when faced with what decision to take about the new sailor, undergoes a sort of emotional block and falls under the sway of a kind of collective depersonalisation. In an effort to end this intolerable paralysis, two subgroups, one hostile and the other compassionate toward the new member, come into violent conflict. Only the decisive intervention of the captain, who treats the newcomer as truly ill, exempting him from work, prevents mutiny and saves the ship.

Essentially, the phantom of violence (the weak striking the strong, who in turn has been violent) and the phantom of death (the ailing sailor) both generate the risk of chaotic confusion, the response to which is a repressive, stabilising attitude. In communities, the centrality of the pedagogical polarity, excessive infantilising of patients and rule degeneration all correspond, in my opinion, to the presentification of the unrecognised phantom of violence or death. Repression by rules begins as an attempt not to confront the phantoms of violence and death with thought and shared attention, but through a tightening of the rules and a caregiver attitude that can even become intolerant.

It is the task of supervision, as well as of the community leaders, to identify the phantom of violence or of death within the context that produces it, in the patient’s unconscious or in the transference, and then reveal to the group its evolution, the course it takes in the individual and its action and reaction mechanisms.

The same goes for certain sexual violations. Many of the patients’ sexual attitudes are not sexual in the strict sense of the term, but express emotions of aggressiveness and violence toward the caregivers in sexual ways. In other cases, sexual violence conceals an attempt to quell fears of death. It is important that caregivers develop the ability at the level of individual and group transference, to place these events within a framework and not consider them mere transgressions. In the absence of this possibility, the transgressive mode will tend to repeat itself, because its objective is not transgression but the indirect containment of the dread of violence and of death.

My intention has been to concentrate on the need for both polarities – the pedagogical and psychodynamic – to be combined, hopefully, harmoniously and without the overly excessive privileging of one over the other, since I believe this goal to be one of the team’s basic requirements for appropriately confronting the problem represented by personifications. By personifications I mean the tendency to consider the other as a loved or hated part of oneself (Gaburri 1997). In this sense, fellow community members lend themselves to bringing out aspects – violent or passive, ideal or rejected, masculine or feminine, and so forth – of the self. Recognising in these personifications and actions the presence of a sort of inner trait that comes continuously to the fore, helps to see not only the real relational aspect but also the use that each subject is able to make of relations with others.

This is a delicate task involving a very demanding rapport between the caregiver of reference and the others of the community, and which contains the serious issue of sexuality in the community. It is important that the caregiver of reference not be perceived (sometimes even with a touch of envious competition or undermining delegation) as an exclusive relationship, but rather as a go-between through which to filter the ways in which the patients personify him/her. In other words, during staff meetings the caregiver of reference and the others should help each other ask: What use are the patients making of us? Did something helpful emerge in the one-to-one meeting with the...
As for sexuality, is it merely an aggression, a show of rebellion or intolerance, or is it also a defence against relations in which the affective dimension – as opposed to the purely sensory or physical – predominates?

In brief, personification helps the subject recognise his/her aggressive and subversive dimension that impedes the other parts of the self to make contact and be present. But it is necessary that caregivers see the patient’s behaviours and fantasies as defences, as the invention of personalities used as “fictitious”, and not merely the angry outbursts of spoiled, arrogant children.

One last note on the theme of daily trauma. Community life offers an infinite number of opportunities for daily trauma, frustrations, betrayed desires, disappointments, infantile hopes, unfulfilled ambitions, impossible loves. It is important that caregivers always ask themselves this question: why now, at this particular moment, is the patient intensifying his alienating identification? Why resort to his/her external mechanism more strongly now than usual? An effort must be made to put the patient in touch with the relationship between trauma and accentuation of identificatory defences. This is that aforementioned wedge, driven in to open up a channel for dialogue between the self and selves.

In conclusion, I would like to recall a fundamental idea. Every patient contains rigid personalities from which he/she has to learn to differentiate. The community is a powerful tool in this sense, but runs the risk of getting trapped in these rigid personalities, or of perpetuating defences instead of elaborating them. A pure and simple application of the rules, ever an appeal for containment, reduction and control of the “foreign body” according to purely “formative” means, can reinforce rather than unravel identificatory defences. Thus a series of conditions must necessarily be ensured.

As soon as possible from the patient’s entry into the community, a psychodynamic hypothesis must be formulated on the possible journey of his/her inner personalities (Rossi, Monti 2008).

It is then necessary that, in staff meetings, all the patients are periodically observed within the group dimension in order to assess how those inner personalities have, or have not, changed. It is also essential to rein in competition amongst colleagues, building instead on the ability to investigate the use each patient makes of the caregivers and each caregiver’s acquiescence or resistance to that use. Finally, it is also essential that the stay in the community not be interminable, so as to avoid the familiarisation of the setting becoming predominant and immutable.

**Bibliography**


Baglivo M.G. *Comunicazione personale*.


Notes

1) Predominantly developed in England at Cassell Hospital and Henderson Hospital.

2) A very interesting example is the Austin Riggs therapeutic community in Stockbridge, Massachusetts. See www.austenriggs.org

3) Predominantly developed in England at Cassell Hospital and Henderson Hospital.
4) One of the first to debate this topic (individuality groupality) was Diego Napolitani following his experience in the 1960s at Milan’s Comunità Omega and Comunità Villa Serena (Napolitani D. 1972).

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