The disease of a person and a group *unaware of being it*

Luisa de Bellis

Abstract

Reflecting on a clinical history with a happy end, on an event which has, all of a sudden, unexpectedly, given back to much more than it had seemed we had been involved with, is without any doubt passionate; but I want at once to move out of any suspicion I want to do << *wild psychosomatic*>>. (Ferro 2006) how one could suppose from the following clinical case.
The considerations I propose concerning the structuring value that a group work has had for the mind of all the participants the patient included; and they are also related to the peculiarity of this group, which except for some partial insights, has never succeeded in representing itself as such.

Keywords: group**,**disease, pain specialists, introspection, care

Clinical history

A. is a thirty two year young man, afflicted with Burger young obliterating Arteriopathy – which led him in the period of three years to progressive amputations until he had no longer his inferior limbs.
It is likely to think that his serious vascularization found a very good ground for its growth in his childhood characterized by both mourning and sudden desertions and a very irregular early youth through biologically destructive experiences. A. is an attractive, intelligent, nice person. He succeeds in his affiliation to the Ward itself, so he is well known in the all hospital, weaves friendly relationships and even a sentimental bond inside. On his first Christmas as an inpatient at the hospital he receives as a gift a television set, for the second a portable PC, around him books, music CDs and video cassettes circulate. The last period of his admission to the surgical ward, lasting for nine months, will lead to a deep crisis in the relations between the inpatient and the team causing his "expulsion" and his following admission to another ward.
On one side, a very speedy degenerative process of his pathology, on the other the relational, social background completely deprived from familiar references, produced a recovery situation for which the hospital was and is even now completely unprepared (post note). Even very serious adverse events as a meningitis, a huge difficulty of controlling the serious painful symptomatology, a massive recourse to opiates (opium preparations), the appearance of necrotic damages to his penis; but even his great emotional involvement, the impossibility of recovering "a more distant" relationship, because of the patient's omnipresence in the Ward, will create a

progressive suffering in the staff , all the people involved will give voice to this in a different way.
A.asked for more and more frequent quantities of morphine, but it did not correspond a fit analgesia causing considerable side effects (sleep disorders, immune instability but strangely there was no drop in the libido). The sanitary staff was divided between attachment and avoidance, between excessive doses and placebos. All the consultants (pain therapist, psychiatrist, psychologist, neurologist) were forced to find appropriate solutions.
In this climate of reciprocal resentment and lack of trust the Head Nurse warned that different nurses don't want any longer to come and work and they reveal several indispositions.
Her request to let them come one after one to speak to me (the clinical psychologist responsible for the ward) transforms into my proposal to organize some collective meetings to discuss about the situation. The nurses' malaise is A.: "he isn't the only patient in the ward"; " he has been spoiled"; " he is an addict". Women refuse to medicate his penis; men can't stand him any longer; at night he always screams; "doctors behave each in a different way: there are those who are generous of analgesics, those who prescribe placebos; those who go to the patient, those who get the nurse". Those who are in favour of a tolerant and loving behaviour quarrel continually with those they think are too severe.
In this stage the make up of a mini team composed by a doctor in the ward, the Head Nurse, the pain therapist, the psychiatrist and the psychologist, all of them have the task to give clear indications of the therapy to follow to agree together with treatments and modifications. All that will have a temporary positive effect both on the ward and the patient. It is difficult to express through words the involvement in that period, and the intensity of the emotions which were activated. Periods when time seems to have stopped alternate to days when it flows in a feverish way, and serene and lively days which seem to give a perspective to the future. The months spent in the decompression chamber to reduce the septic state of the broad wound in the last stump refusing to heal; on A.'s part requests for exceptional attention alternate with feelings of abandon, desire of being free and terror of being alone.
The discharge agreed with a friend of his representing his reference with the external world seems the only possible solution to lighten everybody. The incontrollable pain brings him back to the hospital after a few days and he is recovered in another ward. The dynamic succession which is activated in the new place for treatments is not very different: At the beginning the state of adaptation with the new circulation of books and CDS, but then the months flow and tiredness, the hints of the recovery of disease, and the sense of impotence and the disappointment from both lead to a new communication of unbearable pain to more and more requests of morphine, to therapeutic oscillations between opiates and placebos. The septic state of the wound of the stump does not recede medications are done in general anaesthesia on alternating days.

The different opinions of doctors about the opportunity of such treatments made necessary a session of the Ethical Committee of the hospital. It happens on those days a self- injuring act, which will mark the culminating point of the path accomplished by the patient and all of us.
The depressive phase is more intellectualized in the relationship between the patient and me. Here, it is possible to mark the delineation of an area where we can define different emotions , where one can face "betrayal" and expulsion, where the concreteness of missing and lost things can find a space in order to think.
Soon after, not withstanding, the trials failed more than once of skin self-transplantation in order to cicatrize the stump and while we were all absorbed in persistent search for appropriate, solutions, A, fell in love, loved in return, by a girl "not in favour of drugs" and through her, he expected a baby.
In three months' time the patient was discharged, he will come back only for the necessary dressings. At the present time, the baby is one year old, the stump is cicatrized, and six months ago the Service of Pain Therapy received back morphine.

Some clinical reflections

Disease as a complex event in the life of a person, the plot of so many personal stories, typical *humus* of institutional apparatuses gave life to a very intense event and offered so many useful means of reading the text.
A first general consideration deserves to be expressed about the different approaches to disease and the patient which characterize the professional interested representatives and the difficulty of finding out a *modus operandi* which should be respectful of everyone.
A psychologist's presence in the *staff* , when doctors don't accept "taking care of emotions", as a circumstance split from the global cure, involves doctors in different relations with their patients so forcing them to use their usual defences. Defence from any involvement with the emotions of the patient and defence from his/her own emotions for fear of these, if they can <<*interfere with their cognitive and decisional processes*>>. typical of their profession (Tommasoni, Solano 2003)
In the paper by A. Fazio, (2004) in relation to a work group with the *staff* of a psychiatric London hospital, both the pathos caused in the doctors by their constant exposition to the pain of patients and the fear which is activated by the intimacy with the other people's suffering and also the vital need to preserve a space protected from these "poisonous" components. All these elements, even if one can change contexts, stories, and the people living them, have a universal value in or for nursing homes and are easily traceable in the clinical history here described.
And again from a groupal vertex is to be considered that the more doctors involved to cooperate, the more their usual procedure forces them to work

adjacent, sometimes contiguous, but rarely together; or better always maintaining the limits of their own specialities.
Around the same leg o orthopaedic surgeons, neurologists, physiatrists, vascular or plastic surgeons, diabetologists can approach or alternate and so on, each of them with his/her order of diagnosis and therapy about tissue or the system of competence.
In the situation described, instead, the features of the patient's personality, his life history, his disease violated all the usual schemata, so obliging the *staff* to take charge on " immaterial forms"- the internal substances in a relation - which are *usually* defined all together as "psychological aspects". Working in *group*, just from the beginning, it seemed to me to be the natural energy or resource to face the constant and brutal oscillations between omnipotence and impotence which each of us is subjected to. The evident aim was the improvement of our service *versus* our patient and on the other side; the purposed but not confessable function enabled us to have had an extraordinary experience. All that seems to have had though through so many difficulties or faults, a leading role in A's life. It is to be considered that a Disease has a constituting value in its own identity for a sick person and, specularly, is fundamental for the recognition of the professional identity of doctors: this enables the training of a deep symbiotic link through which a sick person can defend himself/herself from the perception of the sense of the self, already injured. Normally, the quality of this link remains nearly completely unexpressed since the affective net of a patient supports sufficiently his/her need of attachment and his possibility of preserving some internal emotional presences. In this case, instead, A's a massive affective requests even given that the absence of external references changed the treating *staff* into a Family and the hospital into the whole Society with all the implications that this burden involves. It was not easy for the Group of Doctors (I mean by this the constellation of groups and subgroups constituted during four years) to face all the consequences which were caused by the representation of an amputated body and yet at the same time to preserve the sense of a possible life in any case. It seems to me that I can say that from a certain moment on our usual roles were inverted; doctors lived the violent and persecutory emotion s connected to the personal experience of dismemberment, faced mourning for parts no more curable or recoverable, while A. preserved the possibility of finding out new strategies for life. The sanitary *staff* even lived the sense of guilt because of the fact it was obliged to act repeatedly and sadistically on a *son*, while A. was progressively grateful for freeing him of his necrotic parts and so permitting him to interiorize good objects. One can state that this path permitted A. to revisit all his fragmented life in order to relive all its main moments and interiorize that necessary looking after it to express his own desires. The home – hospital, even through the presences of two operators who were a constant reference in all the phases of this experience, made possible the creation of *a less unsure* base, so permitting A. to live an adult effective relationship and to move home. The active

role, the patient himself had inside the nursing group whose effective member he always considered himself and what has never permitted us to relax our guard, was the reason for a lot of interest and astonishment. Inside the group between alchemy and chemistry this feature of it was defined in many ways: courage, *esprit vital*, attachment to life, internal force, what is defined, *"a certain something"* interfering greatly with what one could expect from the massive use of opium preparations (sleep disorders, immune instability , but strangely, not a drop of libido, capable of influencing chemical – biological answers which seemed predictable and of interfering greatly with the noradrenergic serotoninergic, dopaminergic systems.

Two more reflections

In the normal psychotherapeutic practice, the interruption of the action is the necessary condition to give enough room to thought. This *dogmatic* statement, which does not need some more words to be understood by those who have a psychoanalytic training behind, appeared to me in its complete clarity in the course of this experience. Every exchange between colleagues was either formal or extracted amid different experiences, which was to be concluded with an indication or a decision about what to do The impossibility of freeing oneself through action , anguish caused, exposed to personal unbearable experiences of impotence, with consequential escapes and expulsions.

May be, it is for this reason that the two reference figures who alternated both for the nursing subgroups and for A. were " the specialists of pain" – a doctor of Antalgic Therapy and a psychologist – may be more accustomed to be *present* in such situations, even when it wasn't clear what we were doing.

Finally, I want to point out another peculiarity I seemed to perceive in this work group: differently from what happens in psychological or psychiatric contexts, where emotions and affections depend on revelation and introspection. I found, in a medical context a great sense of decency to express emotions in public. What one can say that in a relationship between two people became too intimate to be revealed even only at the presence of a third person even if this person was involved in the same way. It is likely that this was due to a need for protection of his/her own professional identity – which does not need to be defended too much in the relationship with a psychologist – but I believe it is connected with something deeper. J. P. Sartre (1943) considered decency a refusal to be exposed to other people's eyes, which robs us from our own subjectivity and changes us into an *object* and crystallizes us in what […] << *I am for others*>>. I believe that, in a sanitary context the implicit discretion for our own nakedness , it is an integral part of decency, it can be connected with the constant exposition of sick bodies to nurse, cure, violate them.

Post Note:

It were 537 days of admission, in the period of time from the first days of June 2003 to the end of December 2004. In the 18 months there were only 42 days of not hospital admission.

References

Fazio, A. (2004). Il lavoro di gruppo con lo Staff in un reparto psichiatrico londinese: dalla disfunzionalità dell'Istituzione frammentata, allo stato nascente di comunità terapeutica. In Corbella S. et al. (a cura di) *Gruppi omogenei*. Roma: Borla.
Ferro, A. (2006). *Tecnica e Creatività*. Milano: Cortina.
Tomassoni ,M. e Solano L. (2003). *Una base più sicura*. Milano:Franco Angeli.
Sartre,J.P. (1943). *L'essere e il nulla*. Milano: Il Saggiatore, 1968.

Luisa de Bellis, Directing Psychologist, Responsable for the Service of Psychology (ACO), San Filippo Neri Hospital of Rome.
E-mail: l.debellis@sanfilipponeri.roma.it