Abstract
The paper means to repropose Therapeutic Community importance and adequacy as treatment process and therapeutic Method. An intensive treatment process to those people who have clinical and existential situations of a certain seriousness and complexity, which can not find a result so articulated in other treatment contexts and methods. We describe the characteristic of treatment model and therapeutic community professional operative organisation so that this very specialistic offer does not lose its own Identity, risking to devaluate both clinic and treatment Subjects. Assessment, clinical decision, treatment guidelines and clinical Research, when they are based on the experience of a therapeutic Model highly professional actually tested during the time as for Therapeutic Community one, define an institutional identity today dangerously questioned by paradigms always less scientific and clinical. The essay highlights the clinical quality of work done by the therapeutic community when the institutions don’t allow own identity alienation and self-hybrid transformation with significant consequences on the results.

Keywords: Therapeutic Community, Assessment, DSM 5, Personality Disorders, Process and Outcome

1. Identity
In an interview on the topic of identity, Z. Baumann offered an interesting observation on the distinction between human communities based on an absolute sense of belonging (“of life and destiny”, S. Kracauer) and communities based on ideas and principles, concerning a classic dichotomy of political sociology.
He explains identity questions arise when you contact this second category. In fact, it presupposes a continuous inner dynamic (comparison, review, repetitive choices, revision, confrontation, reconciliation of conflicting and sometimes incompatible needs, and so forth) by which those communities can be kept together, linked by the ideas and principles into a polymorphic and changing cultural world.
If we think back to the birth of the Therapeutic Community, to the ideas and principles that have sustained and guided it over time, to the current debate in some Italian regions concerning the new accreditation rules demanded by the local health authorities, and to the ongoing discussion within the English movement Community of Communities where the “real” therapeutic community was born, in R. Hinshelwood words, we cannot do without finding a profound topical pertinence and current events in this observation.
The Therapeutic Community is, indeed, an idea and principles community. As such, it is inevitably immersed in a continuous dialectic within itself, and with the outside world, a debate that makes the identity of therapeutic communities a constant work in progress.
As inevitable as it is to state that the interpretation of the original ideas and principles of the therapeutic community, founded on therapeutic theories and techniques, has always depended heavily on the personalities and features of their various founders, their ideas and principles, we can agree that they all share what J.S. Whiteley and Gordon J. defined in a 1979 article as the classical theoretical concept underlying the first therapeutic communities. He was referring to the democratic treatment model proposed by T. Main and M. Jones in place of the hierarchical and authoritarian hospital model. That is the model currently increasing its impact on the global economy and new government policies, in addition to new clinical and social issues.
How then, even in these changing times, the therapeutic community be allowed not only to preserve but to assert itself further, its unique features and spirit, alongside an idea about technique and ever
newer psycho- and socio-therapeutic processes that respond to the variegated and, at times, unprecedented needs of patient populations, their families and – why not? – caregivers themselves. And how can patients be afforded both a chance to be designated according to common factors, which inevitably de-individuates but permits a common therapeutic approach that fosters the creation of a shared and shareable mental space, as well as according to their own subjective specificities, even those most invisible and concealed, in the words of A. Correale?

How to ensure that this process of change offered by the therapeutic community maintains its coherence and effectiveness against the threat of treatment standardisation, lowering of professional qualifications and skills and lack of homogeneity in clinical aspects?

Dichotomies: the assertion of the therapeutic community’s identity, versus its need for renewal; a scientifically founded approach to identity homogeneity of the patient population versus a more authentic rediscovery of the subjectivity of the person. How to lead the antagonism of the parties to an informed and well-articulated clinical practice? How to ensure that the integration of ideas and values can be what frames the institutional identity so as to dialectically unite both dichotomies in an approach to intervention that is both technical and relational, as well as congruent and efficient?

To produce a possible answer, we must perhaps allow ourselves to explore the terrain at which we move, admitting that there are some unresolved issues today concerning patients, instruments and methods.

At a time when more and more clinicians agree that psychiatry must concern itself with the multi-problematic nature of complex patients, perhaps the question of treatability or non-treatability has to be reconsidered.

This could be an initial assumption.

At a time when the structure and organisation of therapeutic communities and in some cases even the very concept of a physical place of treatment, from planning and financial needs onward, are being calling into question – which inevitably unsettles the more profound sense of the so-called community therapeutic setting (consider, in this regard, various experimental adaptive approaches currently in use in England where, as R. Haigh reminds us, there are those who seek to compensate the closure of facilities with the idea of a community model replicable “in the mind”, and therapeutic approach without a physical structure), the re-conceptualisation and re-definition of the community therapy “instrument”, in all its most concrete forms, is highly significant. Here we have our second assumption.

At a time when the challenges of rationalisation and welfare costs containment are imposing both new and revised therapeutic assets, the choice of a treatment method such as the therapeutic community must appear highly appropriate to the therapeutic needs of the person – the Subject of the treatment. Processes of clinical assessment, therapeutic planning and analysis of treatment results require the support of precise experiential and research data evidence-based capable of justifying the adequacy and judicious use of resources and patient placement.

This could constitute a third assumption.

If it is true that we are living in times of crisis necessitating revision of the use of resources, we cannot, however, forget World Health Organization director general Ph. M. Chan’s wise admonishment on global mental health: finding a way to define more effective leadership and governance to be able to offer mental health and social services more capable of responding to the needs of the community. Producing strategies for promotion and prevention, strengthening information systems and supporting research that yields ever more evidence-based data, must be the primary objectives that States set for themselves in the years to come.

Some reflections on these themes, therefore, without presuming to be exhaustive, would be worth making.

2. New aspects of psychopathology
As we have said, the environment of psychiatry today often uses the term complex multi-problematic patient. A rather cumbersome and superficially descriptive definition that, nevertheless, could allow us clinicians access into the meanders of that complex mesh between the multi-faceted world of inner experience that is hard to fit into a single diagnostic category, and the external one increasingly manifested through interpersonal relations and disturbed behaviours that, in turn, generate existential intersections that make the subject always less categorisable in an only perspective. It is in these terms that care and custody, for example, whose original meanings are so distant, frequently end up assimilating each other.

This definition of the complex multi-problematic patient, therefore, challenges, if possible, that already a highly articulated area of patient treatability and non-treatability that M.H. Stone described so well, leading us to the consideration of various factors that can affect a patient’s treatability and our expectations as caregivers. A definition that, in any case, shows a related qualitative advancement, we could say, as compared with another in vogue a few years ago. The term “difficult patients” was clearly a semantic choice alluding, first and foremost, to the efforts made by caregivers, that risked placing the therapeutic effort considered necessary ahead of those aspects of the Person that characterised the Subject of the treatment. An undeniable foregrounding of those highly egosyntonic aspects of certain patients, an egosyntonic experience that is often realistically present (and unwieldly) that, nevertheless, risk not only to render incomplete and unconstructive the inner experience of these patients, but also the therapeutic experience of the caregiver.

The gravity of mental, affective, personality and psychic disorders, at times, accompanied by severely compromised capacity for self-regulation and primary psychic deficiencies, comorbidity, seriously impaired functioning, substance addiction or abuse, in addition to the presence of various consequence concomitant (e.g. legal) problems, calls for new treatment and treatability paradigms. It may be necessary to rethink how these paradigms inevitably require the active participation of each role in the process, by all multiple subjects, thereby restoring the idea of a network. A system that must expect a substantial capacity for integration while at the same time safeguarding the individuality and responsibility of the subject of treatment, the client, the Person.

Indeed, one of the definitions for these “treatment-resistant patients”, according to E. Shapiro of the Austen Riggs Center, explicitly expresses not only the possibility of an unfavourable result, but also teaches us a possible hostile stance to a request for treatment that takes the risk of being mono-directional – caregiver/referrer to patient – and devoid of those processes of activation and responsibilization that, as every psychotherapist knows very well, can lead to deep change.

**With these highly complex patients, whose direct motivation to seek treatment is either scarce or non-existent, the risk of adopting a passivating, medicalising approach is high. As is also the danger of seeking not treatments but possibly more social than clinical places and times of hiatus.** This may seem the briefest less investment-burdened route, but how authentically lasting, efficient and therapeutic is it in clinical, personal and social terms?

It is perhaps unavoidable to think that the treatability of these complex multi-problematic patients has to regard their availability to activate cure processes and multiple changes. Processes whose activation requires trained, skilled staff and robust clinical models capable of fostering significant variations in the quality of the patient’s identity and sense of self, as well as capacity for emotional and behavioural regulation. This calls for – to underline the point once again – organisation, environment and staff.

The need to activate processes that concern possibility and capacity to develop significant object relations in settings that encourage their elaboration and their evolution toward the person’s more efficacious psychic and real life, makes it interesting to contextualise both the intrapsychic and interpersonal dimensions – which to I would also add the temporal one – within a well-articulated therapeutic apparatus. **The patient who initially leans heavily on his inner defences rather than activates healthier resources must indeed gradually acquire the ability to test new kinds of emotional experiences and the following behaviour.**
A therapeutic apparatus backed by an ethical and deontological neutrality that does not deprive patients of their Responsibility, Authority and Power in what is, in turn, a complex system of constant interaction and integration. We have to hypothesize relational and therapeutic methods that make it possible to treat, as much on the level of meaning as possible, those symptoms and behaviours that are often the sole primary access to that fragile, disturbed inner world of those patients we are increasingly faced with: patients whose serious lack of capacity for symbolization, and therefore for use of speech, is compensated by symptoms and behaviour.

It is, therefore, possible to suppose that these patients’ treatability stems precisely from the decision not to foreground compliance, stabilisation of symptom and behaviour, or exterior or physical containment of that extreme affectivity that often accompanies those powerful relational dynamics that spring from equally potent representations of the self or the other.

We can think that treatability is represented in therapeutic paradigms that make it possible to exhibit and retranslate what happens into meanings, and to learn from the relational experience, without resorting to a pharmacological or behavioural focus, in order to restore the word, conceptualisation and mentalisation so scarce, non-existent or deviated.

We may experiment that treatability comes through the counter-transference “experiences” of therapists and the caregiver team that are important to understanding patient’s mental and emotional states, without however producing methods that merely supportive or passivating. That help can result from a complex system consisting of responsibilizing reception, relational containment and a firm but always present holding, which can contribute to creating degrees of neutral intervention in response to the multiple partialities contributing to the patient’s inner conflict; that patient’s capacity for exploration and reflection on what is happening here and now through tolerance as well by staff and caregivers about patient’s confusion, and on what he generates within the environment, with a view to identifying the deepest psychic dynamics, thereby fostering a highly sophisticated treatability against the backdrop of a group setting where the exploration of mutual understanding also becomes an element of this treatability.

There are treatments in which the daily clinical practice has proven to have therapeutic potentials with complex multi-problematic patients, whose treatability seems, therefore, to become possible in interactive settings that encourage it, permit it and allow for its exploration and interpretation. This brings us to our second assumption, treatment environment and structure.

3. Questions on the therapeutic community’s organisational model

The therapeutic community is a treatment setting and method that, first and foremost, establishes an “interpersonal field” where what in Lewinian terminology we could define force fields: instruments, work models that range from the psychotherapeutic relationship to clinical technique and much more, but also the community staff and residents, which together permit an experimentation of the self that represents both a social and clinical process.

When that which takes place in the therapeutic community has to do with a constant and continuous process of self-enquire and examination of its objective reality, we actively invoke concepts such as mentalization, transference and analytic counter-transference, along with concepts such as personal and social responsibility.

A therapeutic context focused on responsibilization, safety, development of personal and social skills, active participation, sharing and integration, is fundamental to the construction and unceasing maintenance of a system of relational, social and therapeutic co-habitation through continuous encounter and dialectic.

Residential living offers the endless opportunity to work on representations of the self and the other, allowing for a process that starting from external reality and accedes to the patient’s inner world. In an environment like this indeed stimulates patients to present their distress and own way of being so as to observe, assess and modulate himself with the other. An other that is not only represented by the individuals within the community but by the community’s entire social dynamic, which is representative of the society itself of person’s life.
Mediating the self with the Other means engaging in a dialectic fundamental to the psychic life of human beings. P. Fonagy and his coworkers referred to the expert observations of J. Bowlby, M. Mahaler, D. Winnicott and others, in clearly outlining the mental and affective evolution of attachment and mentalisation. Processes in which not only physical contact – on the contrary, above all “mental” contact – with the other and the capacity for representation of the other’s reality and constructing its meaning and for connection with factual reality, generates an individuality distinct and yet open to correspondence with the elaboration of the representation of physical reality. It is precisely this constant tension between the self and the other (objective reality) that permits a vital and constructive correspondence between the real world and the mental representation. Correspondence that allows the cognitive, psychic, affective and relational adaptation that, in turn, allows for existing in the world as an individual and a social agent. The inhibiting lack of social control that underlies the concept of “sharing”, a sort of community democracy, allows for a certain margin of dialectic freedom within the environment. In reality, once again it is that attitude of neutrality and transparency that facilitates the shared own human experience, both affective and mental, and the feeling of belonging. An own experience that does not take place in an environment “dissociated” from outside life, and which permits the community not to raise an ideal “world apart”, away from life in the real, daily, social and familial world. Consider, for example, how much more often today we find ourselves confronted, during treatment, with the judiciary authority and external law that have referred offender patients; and to what extent, therefore, therapists and patients are forced to explore reality together while also confronting the judiciary authority and the laws of the outside world – as well as symbolic law and the coherence of their therapeutic processes. The obligation to undergo treatment, and consent to the same, thus become salient factors in not only the patient’s but also his/her caregiver team’s continuous process of introspection and dialectic. An unavoidable framework within which the treatment of offender patients is located.

For these process to take place, it is necessary that this interpersonal field offers a space and time not only sufficiently stable and safe for all parties concerned, in the pragmatic sense of those terms, but also in a purely conceptual sense.

**If a community’s therapeutic system is not underpinned by a solid thought of itself, it could produce overly-articulated hybrids that threaten to alter the way in which it works, with severe outcome consequences.** Outcomes whose assessment would have to be carefully correlated with indicators about correct treatment practices in order not to veer into distorted consideration on the iatrogenicity of intensive and residential forms of treatment.

In a recent article, R. Hinshelwood presents and reminds us of how elaborations of what the Therapeutic Community offers can differ so much from its English origins as to call into question its very meaning and conceptual features. Elaborations that can represent the loss of one of the therapeutic tools for intensive and residential patients treatment, which continues to be a clinical requirement, which the need to cut health care costs cannot ignore.

Hence, the recurrent need to reconceptualise and optimise resources, models and community treatment modalities based on a clear and inescapable identifying notion. One that challenges attempts toward an overall flattening of the treatment system into a series of standardised responses and presupposed homogeneity of patient needs, leading to the loss of the “Clinic” and the “Subject” – and all this in service of the purely welfare and at the expense of therapeutic benefit, with the risk of an implicit recourse to the use of drug therapy in place of the relational intervention that is inevitably lacking in the absence of a sophisticated and skilled professional organisation.

In a framework of this sort, the treatment offered to a particular patient must be able to respond to the treatment subject’s suitability and therapeutic needs, and to intervention solutions appropriate and modulated in function of those last.

The reduction and containment of public and private expenditures today demand processes of clinical assessment of patients’ therapeutic needs, therapeutic planning and analysis of treatment outcomes that, through clinical experience and research data, can justify the use of resources.
The real issue is to integrate that concept of complex multi-problematic patient treatability with the idea of structuring and to organise the setting and community therapy instrument, to achieve an operational and functional application. One that begins with the initial contact with the user and the entire referral system and then proceeds through assessment, project meaning construction, therapeutic alliance and is represented in the process of acclimation and therapeutic negotiation that is then the start of the treatment itself.

Offering specific treatment by functioning typology and clinical incidence on macro areas such as personality disorders and psychosis seems to us an adequate initial response to the need for congruence patient placement.

**“Relatively” homogeneous patient groups** may share a more cohesive environment and treatments can prove better targeted. (1)

Our experience induces us to think that the daily space shared in compliance with belonging assets and interpersonal organisations, and the mental space constructed in relations between peers and caregivers and associated with assimilated thought processes, impact strongly on the atmosphere and therefore the setting itself, whose modulation becomes pivotal to the specificity of the treatment.

Indeed, the shared and shareable affective, relational and mental experience that favours exchange on both the cognitive and emotional planes, produces a significant resonance that goes beyond the individual, is both inside and personal as well as group-related, and allows for subjects’ active participation the mentalisation and object relations processes actively participated by the subjects, even when they are not recognisable by themselves at various levels of awareness.

The transerfential dynamics make use of elements of consonance, refraction and mirroring that facilitate communication, a more useful empathic exchange, a lower subjectivity in the interpretation of events and feelings, a strengthened identity dictated by a sense of belonging and a more immediate availability to bonding and attachment.

In the “relatively” homogeneous group, elements of intersubjectivity seem to be constructively valorised, which effects on processes of motivation and attachment, relation and conflict, using which the subject confronts and challenge him/herself, dialogues and reflects. That, in the end, supplies constructive resources for own subjectivity and individuation.

Caregivers themselves and the various institutional staff, along with patients, in a reciprocity and interaction that is always interesting to observe, as R. Hinshelwood ("Creatures of Each Other: Some historical considerations of responsibility and care and some present undercurrents") teaches us, contributes to build and maintain those processes that end up conditioning the atmosphere, interactions, rules, modes of containment, implementation of specific elaboration processes, etc. that delineate how a work team functions and its context.

A functioning and setting that are them the object of exploration at the moment of assessing whether a patient is admissible to the Community or not.

**4. The start and target of the course of treatment**

For the purpose of assessing a potential course of community treatment, assessment of the psychopathological features and behaviour of the person deserves to go beyond strictly nosological aspects to consider those more descriptive of how the patient functions in a variety of areas.

Assessing functions and not symptoms, dysfunctions, impairments of areas of the self and resources helps to provide not only the broadest possible picture of the person but also the elements upon which to base and calibrate possible interventions.

Indeed, some of these items will be indicators that provide greater insight into the choice of treatment technique, for example through group activities and specific themes, or else with other more individual interventions.

Deficit or capacity of mentalization, style of attachment, level of impulsiveness, quality of object relations, function of exams of reality, level of insight, features of the Sense of Self, anger and
aggressivity management, modulation of emotions, and so forth, offer useful elements for the
construction of intervention guidelines and a personal treatment plan.
Building a course of assessment (2) allows the group of clinicians to focus on patient’s various
features into focus and, in the end, construct a single viewpoint that derives from a highly detailed
process rich in observation and data. But not only, in the conviction that patients have many things
to say about themselves, and in order to launch the process of enquiry and responsibilization
immediately, a targeted assessment makes sure that the patients themselves can start to mentalise
how they perceive and reflect on themselves and on how they attribute meaning to the intentions of
others, on awareness of their problems and moments of crisis and on what goals they feel they need
to work and take responsibility for. Thus the concept of diagnosis in the therapeutic community
must be understood as a multi-focal and multi-disciplinary process in which the patient also takes
an active part.

The therapeutic community offers a rare opportunity in individual diagnostic and therapeutic
processes: a multiplicity of points of observation (workers with a range of skills, the proximity of
patients, daily routine, informal moments, peer groups, the longitudinal and temporal line of
observation, etc.), and a space (and time) for reflection and construction of a shared thought that
allows for integration of the parts. A sort of space for the inter-visualisation of the clinical case; the
moment in which a shared mental representation of the patient is formed, which will make it
possible to give structure and organic way to the strategies of the clinical intervention.

Diagnosis and treatment planning, therefore, become the result of a combined group effort that
makes room for elements of relational understanding that take place directly “in the field”, elements
of both a medical-psychiatric and a more strictly psychological, psychotherapeutic and educational
nature. Shared reflection allows for the immediate creation of space in which the various
professionals interact to create a common language and, finally, single vision, which arises from the
integration of multiple observations and voices. A common view, born of differences and essential
to the construction of coherent, stable and seamless treatment guidelines free of procedural and
theoretical gaps that could damage the necessary coherence of the intervention. Confused,
fragmented, low functioning patients, or relatively low levels, often with obvious identity deficits,
need to have a coherent rapport with their caregivers. That coherence that will offer the point of
departure in forming a relational alliance will permit the construction of meaning, willingness to
accept treatment and, finally, the patient’s real commitment to the process of change.

5. Assessment and theoretical references offered by the DSM-5
In other words, it must be clear that for a valid assessment not to be reduced to a sterile descriptive
– or worse yet, labelling – exercise, it must:
a) be understood as a process, an interpersonal undertaking that develops over time and is
aimed not only at identifying the current problems that have led to the request for intervention, but
also at viewing them from the perspective of the client’s personality;
b) encourage the active involvement of the patient in the co-building of a clinical
consciousness (the use of questionnaires when necessary and useful is optimal);
c) gradually build on the subject’s aware participation in the co-construction of a process
aimed at the identification and management/resolution of current problems: the clinician must keep
the patient’s motivation high;
d) be custom fit to the perceptive clinical needs associated with the particular individual client
– beware of prefabricated assessment packages;
e) have a conceptual structure that allows for the combination of a variety of methods and
voices concerned with outlining as precise a profile possible of the patient’s weak points, including
symptoms/signs of mental disorder, and strong points; they should include at least one self-
administered measure and one based on the assessment of a clinic other than that of the first
interviewer;
f) be based on a process of challenging hypotheses, and not a confirmation of “first impression bias”: the initial meeting(s) should generate hypotheses useful to identifying a subsequent testing strategy;
g) include test assessments when necessary; the tests are nothing more than standardised “behaviour samples” that help the clinician get a sense of the patient’s mental response to a broader range of situations than that of the consultation, and increase the ecological validity of the clinician’s assessment;
h) be based on scientific evidence and not involve instruments or protocols suitable for research but not in the clinical setting;
i) be in close continuity with the treatment programme, of which it must be a facilitating element that links the working alliance of the assessment with the therapeutic working alliance; the identification of the treatment’s initial objectives and their hierarchical scheduling over time should be done at the end of the evaluation phase. Assessment and therapy are not separate, independent (or worse, opposing) moments, but contiguous and part of the same therapeutic enterprise;
j) be consistent with the therapeutic intervention model and include both descriptive and “inferential” elements and, in any case, must be useful and understandable to the patient. Inferential models help to enhance the meaning of descriptive aspects that have been highlighted, the absence of which could produce unilateral speculations on the part of the clinician that the client may find difficult or impossible to understand. In other words, descriptive models must precede inferential ones during the assessment, always keeping in mind that there are no data that permit “bi/uniqueness” in the relationship between inferential and descriptive models. For example, in the case of a borderline personality disorder diagnosis, there are dissociative dynamics under way, just as when dissociative dynamics are noted, there is surely a borderline personality disorder. In other words, we must always depart from a complete collection of descriptive aspects, inserting inferential elements in order to further “open up the meaning” of the client’s experience. Descriptive aspects must always be based on reliable and valid operational models; for symptomatological aspects, we consider the DSM-5 optimal;
k) assessment methods and instruments must always be tolerable to the patient. It is precisely the clinician’s responsibility to strike a balance between the diagnostic accuracy and utility of the toolkit, on the one hand, and the patient’s emotional ability to tolerate it on the other. It is also the clinician’s particular responsibility to properly administer highly emotional tests (e.g. AAI, projective tests, etc.) to the client, as well as manage eventual symptomatic eruptions associated with assessment;
l) increase the client’s sense of the narrative recognisability, predictability and consistency of his/her existence;
m) be shared with the subject in the phase of assessment restitution;
n) increase the amount to which the representation of the subject’s mental processes can be shared with the members of the therapeutic team (help all those involved to achieve a consistent “mindfulness” of the patient).

When the assessment of the dysfunctional personality is of interest, the DSM-5 offers an Alternative Model for Personality Disorders (AMPD), which has numerous advantages compared with the model included in Section II, which is a simple cut-and-paste of the personality disorder criteria included in axis II of the DSM-4. Although this is certainly not the most appropriate place for a thorough examination of the AMPD, it would be worth highlighting a few points that make is considerably superior for clinical decision-making, especially in the community framework, as compared with the older model:

a) it contains a precise definition of the central functions of the adaptive personality – a self and interpersonal function – and considers personality pathology the result of the impairment of these;
b) while maintaining the possibility of six distinct diagnoses (avoidance, obsessive-compulsive, schizotypal, antisocial, borderline and narcissistic personality disorders) the AMPD is primarily dimensional (or a dimensional/categorical hybrid), which make it possible to custom fit the assessment to the patient instead of forcing the patient’s experience into predefined and scientifically invalid categories;

c) its central element (referred to as Criterion A) requires assessment of the aspects considered by the majority of clinicians in their usual assessments: the compromised Identity (function of the Self), Self-Direction (function of the self), Empathy (interpersonal function) and Intimacy (interpersonal function);

d) it gives clinicians a scale for assessing specific impairments, the Level of Personality Functioning Scale, which goes from 0 (maximum functioning) to 4 (maximum impairment of functioning): a score of 2 in at least one of the four sub-functions of the self and the interpersonal function is necessary for diagnosis of personality disorder;

e) once impairment has been ascertained in the central areas of personality functioning, as well as how serious it is, the AMPD asks the clinician to complete the assessment in terms of the intensity of the expression of dysfunctional features – i.e. of mental functioning – and not in terms of the presence or absence of symptoms (as in the DSM-IV). This yields a model of the patient’s personality pathology continuous with decisions regarding the treatment process, consistent with the way of thinking of the community clinicians (and not only), that helps to link maladaptive dimensions with, on the one hand, the impairment of the central personality functions and, on the other, with potentially adaptive traits, facilitating that aforementioned diachronic vision that leads to a creative clinical hypothesis regarding the client’s dissonant evolution;

f) the model seeks to eliminate the problem of clinically useless diagnoses (e.g. mixed personality disorder) and diagnostic overlapping owing to categories that set up arbitrary borders between continuously distributed dysfunctional features;

g) it offers the clinician a system that is flexible also in descriptive accuracy, that goes from 5 general dominions to 25 basic features for generating a client profile;

h) it remains a robustly trans-theoretical model (i.e. usable by clinicians of a variety of backgrounds, that integrates the common central elements of the principal clinical personality theories) and is founded on scientific research;

i) it is a model that can be used for certification purposes (medical/legal);

j) it has a range of instruments for Criterion B (dysfunctional features) assessments, familiarly referred to with the acronym PID-5;

k) it is designed specifically to permit diagnosis not only of problems identified in adults but also the personality dissonances that emerge throughout the life-cycle.

In brief, these observations heavily underscore how clinicians operating in the community setting should consider the AMDP and the DSM-5 as pivotal to the assessment of their clients’ personality dysfunctions.

6. Research and studies on treatment outcomes

The ever-growing need to confirm the adequate use of resources based on the results of treatment makes it more urgent than ever to be able to monitor and assess change, that is the effectiveness of the community intervention, but it remains a long way from being implemented.

Indeed, to date, the process of research that can yield an assessment of the results of a community intervention in terms of effectiveness is still to be considered highly sophisticated. Studies on the effects of treatment are oriented in function of the various research approaches. A method outcome research, which seeks to avail itself of standardized tools capable of measuring both general and specific individual dimensions inherent to patients’ disorders and problems (standardized tests, scales, etc.) generally compares the results of initial and final assessments with a view to ascertaining whether the treatment has effectively reduced symptoms and distress and produced a more integrated and adaptive person. The particular attention devoted to those effects of treatment
that patients perceive and deem more relevant – for example, modification of the “ability to function” in their daily lives, sense of satisfaction or, in the case of chronic disease, quality of life – render outcomes often patient-oriented measures, aspects that in order to be exhaustive, must be combined with a range of less subjective indicators.

The process research, on the other hand, which is usually based on hypotheses regarding the psychopathological matrix of the patient’s problems and during the therapy’s strategies for change, making periodic checks independent of the final outcome, and tends to combine theoretical data in order to ascertain not only if and how much, but why a treatment works with a particular type of patient and not with others, what psychic processes are activated and in what attitude personalities are changed.

While it is certainly true that the scientific community is currently trying to evolve away from its heavy focus on process and outcome toward observation of the process variables most responsible for a certain psychotherapeutic result (Burlingame, Strauss, & Joyce, 2013; Di Nuovo, Lo Verso, Di Blasi, & Giannone, 1998) we can agree with J. Lees on the need for comparative quantitative and qualitative research on therapeutic communities that contribute to supporting the clinical evidence on the effectiveness of community treatment, an issue with regard to which much work clearly remains to be done:

“It is clear that we need more, and more good-quality and comparative, research on therapeutic communities, in order to counter the charge that there is not a proven case that therapeutic communities are effective, and that they are expensive. There is clinical evidence that therapeutic communities produce changes in people’s mental health and functioning, but this needs to be complemented by good quality qualitative and quantitative research studies”.

(Lees et al. 1999).

Conclusions
We have spoken here often of the community as a treatment tool, but perhaps, to conclude this series of observations – which, as we have said, must remain dialectically open – we must finally permit ourselves to define the community as a real therapeutic treatment method. A method of intensive treatment for those people with complex and severe existential and clinical conditions that cannot find such an articulated response in other treatment methods. The community, as a method, has its organisation, timeframe, specific clinical training, space and everything else required for its institutional identity. A special identity that reflects the accurate Treatment Method and the professional operational Organisation of each facility, which is, in turn, able to define itself as focused on a particular type of patient and treatment need. The possibility for the choice of therapy, therefore, through this plurality of specialised offer, makes it possible to restore resonance to parameters that foreground the treatment subject and the clinic, a resonance that is today endangered by the predominance of other rationales ever more distant from these.

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Notes

(1) There are various studies, reflections and positions on the effectiveness of the treatment of homogeneous patient groups, as indicated in an interesting text published in 2004, edited by S. Corbella, R. Girelli and S. Marinelli.

(2) By “assessment” we mean the global and differential evaluation of the patient, in his/her unique and complex psychology, in consideration of his/her resources and limitations. The term derives from the Latin *assidere*, meaning “to sit in judgement” and also from *assise*, “municipal judges”. The English word means “to evaluate, estimate, judge”; it can also mean “ascertain the value (of something) while underscoring (in psychological terms) its process-oriented aspect rather than the final evaluation itself.

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