Notes on the report

by Renzo Carli*

1 – Introduction

The report is an important tool in the clinical psychology profession; it can be described as the *necessary complement of the relational experience* characterising and underlying the clinical psychology profession; it is an essential practice in pursuing the goals the profession sets itself. There is no clinical psychology profession that is not relationship-based, but for the purpose of making sense of the professional relationship, it must be completed with the report. The report, in other words, is the practice required for 'thinking' the emotions involved in the psychological relationship.

The report that we are talking about concerns the *relationship* between the clinical psychologist and the interlocutor of the clinical psychology intervention.

Reporting therefore means using *categories that refer to the relationship*, *in order to think of the emotions in the relationship and to speak about the relationship itself in terms of specific goals.* In the sense in which we use it, the report does not concern the other, his/her psychopathological features or his/her behavioural modes in the relationship with the psychologist. It is very important to distinguish between a report concerning the other, which could be said to resemble what is written in the medical record of medical practice, and the report that concerns the relationship characterising the clinical psychology intervention.

The key words in discussing the report for us are therefore: relationship, categories, goals, emotions, thinking, talking about.

Making a report entails passing from acted out or thought emotions in the relationship, to a categorization of the relational events through language, both written and spoken: for instance, in interpretation or even more so, in construction[1].

The narration of a series of events, for instance in a supervision relationship, is not exactly a report: the story takes place, in fact, within a new relationship that should itself be reported. From our perspective, a report entails "thinking about" the relationship; this comes about through the use of categories and models capable of organising what has happened in the relationship, and of comparing the events with the specific goals of the psychology profession. 'Thinking about' is therefore reified in 'talking about', since by reporting we indicate a practice that is made real in language.

Giving a report always means going beyond what has happened in the context of the relationship; it means giving a *new sense* to the relationship, not to be identified with the time spent in the relationship itself. The report, in other words, is characterised by some *new* elements compared to what is experienced in the relationship. As we shall see, it is important to define the level on which to place these new elements that appear in the report: they may concern the relationship itself; the goals of the clinical psychology alliance; the context of the alliance; the institutional sense of the relationship; the work conditions in the relationship domain; the features of the relationship that

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[1] On this, see the work of S. Freud: "Constructions in analysis" (1937). Remember in particular this passage from Freud's book: "If in expositions of analytic theory one hears little about <<constructions>>, this depends on the fact that it is instead <<interpretations>> and their effects that are talked about. But I think that <<construction>> is by far the most appropriate definition. The <<interpretation>> refers to what one does with a single element of the material: a sudden idea, an action not accomplished and so on. One makes a <<construction>> on the other hand when one presents the analysee with a passage of his forgotten past history, more or less like this: <<Until year 'n' of your life, you considered yourself the only, unchallenged possessor of your mother; then a second child arrived and with him a serious disillusionment. You were abandoned for a time by your mother, who even later never devoted herself exclusively to you. Your feelings towards your mother became ambivalent and your father took on a new significance for you>>, and so on" (the quote is from pages 544-545 of the Italian translation cited in the bibliography).

make it useful, useless or at times downright impossible; some new elements of the theory of technique supporting the relationship; the characteristics of the other and of his/her way of being in the relationship or in the bonding situation typical of his/her existential experience, and so on. We believe that an analysis and a classification of these new dimensions of the report can help to capture the specificity of the report itself, in the sense in which we are using it.

In short, we are suggesting a very close tie between the experience of the relationship and the report, in the context of the psychology profession. Why is that? We believe the *relationship* entails a sort of emotional immersion of the clinical psychologist in the matters entailed in relating to the other. Every experience of relating is an experience in itself, unrepeatable insofar as it entails emotional symbolizations situated in the *hic et nunc* of the relationship between the psychologist and that specific person (group or organization), in that particular moment, within the collusive dynamic that structures its goals and purposes. Admittedly, the psychologist is trained to "think emotions" in his/her professional relationships, and therefore to offer the interlocutor a sense of the collusive emotional dynamic underway; this is possible with interpretation, interpretative action, and the construction of sense. It should be remembered, on the other hand, that clinical psychology work is organized within a time-span, with discontinuities and recurrences: sessions repeated during the week, in the case of psychotherapy, seminars at set intervals such as fortnightly or monthly, in the case of an intervention of training or of discussion of the cultural dynamics of an organization; client meetings throughout a specific period of time, in the case of the establishment phase of a psychosocial intervention; group meetings with different components of the organization, and their distribution over a specific time-span agreed with the participants, in the case of the psychosocial intervention itself. Why is clinical work distributed in this way over time? Perhaps not enough questions have been asked on this issue. We believe that one reason for all this lies in the possibility for the clinical psychologist to give a report: in other words to organize what is happening in the work into categories that enable the innovative aspect of the experience to be identified; and therefore to report the experience, to *oneself*, to *the other* participating in the intervention, to the *scientific community* the psychologist belongs to and which s/he wants to keep informed of his/her work, of the ideas the work enables, and of the theory of technique being experimented.

Without the report, therefore, there is the risk of repeating the relationship *ad infinitum,* without pinpointing the innovative aspects which are difficult to see and to conceive if one is emotionally immersed in a collusive relationship.

If the relationship entails "thinking emotions", the report then becomes the opportunity needed for a metathought on the emotions within the relationship itself. We wish to underline this essential aspect of "newness" that the report involves. It is this newness that can constitute the driving force of change and growth that the clinical psychology intervention wants to establish and promote. We know that the time schedule of psychotherapy or of the psychosocial intervention also have the function of allowing the development of reflection on the experience by the patient or by the one acting as client and/or participant in the intervention. Also the patients and participants in the intervention need time to think about the experience, and therefore to make a report. And for them too, thinking about the experience often means identifying the new elements which it is hard to find if one remains emotionally immersed in the experience. But this reporting may or may not occur for those who use the psychologist's work. For the psychologist, on the other hand, it is an essential task. It is the only way of making sense of the follow-up to professional experience: to elaborate strategies aimed at promoting and making future development possible, to lay the foundations for a hoped-for development in the relationship, and also for the development of the patient or of the organization benefiting from the intervention.

Making a report means making sense, but in the sense-making the experience is transformed and its innovative components can be seen. We should remember that the psychological relationship has its own specific features: it is a relationship with no declared, apparent transformational aims, apart from shared ones. Entering a *relationship with no transformational aims*, means accepting that the only emotions, deriving from the reciprocal affective symbolization of the relationship, are the shared elements of the relationship itself. The aim usually enables one to experience the curbed, tamed emotions, contained within the rules of the productive relationship. Think, for instance, of a high school class during a lesson: the shared aim (an oral test, reading a literary text aloud, working out an equation on the blackboard, the teacher explaining a fact or a historical

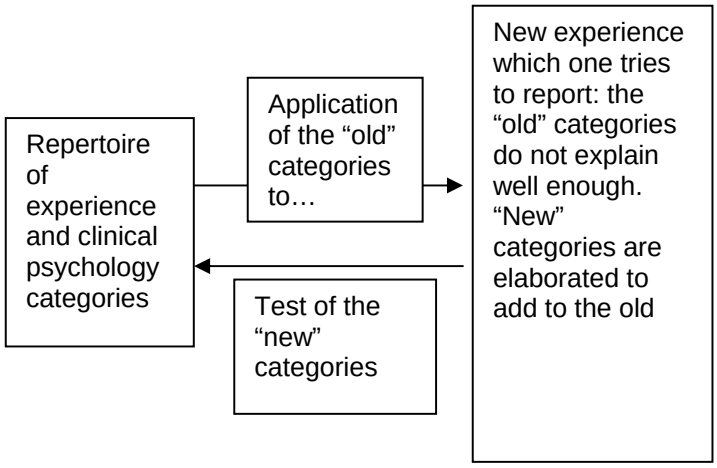
period) reins in everybody's emotions to stay within the rules of living together at school. Admittedly, there will be the more "unruly" or "disattentive" pupils, there will be class-mates chatting in whispers about something outside the lesson, but this is all controlled, somehow restrained by the shared aim. It may be interesting to look at what happens in the break between one lesson and another: at the sound of the bell there is a sudden confusion of voices and noise, due to the end (temporary and reversible) of the systems controlling school production and to the sudden emergence of "another" production, that of the uncontrolled expression of emotions. Now, clinical psychology activity often means that the relationship has no production goals; that the rules of play concern only the structural condition of the relationship itself. In other words, the clinical psychology situation (for instance, a psychoanalysis session, the encounter of a psychotherapy group, a client meeting or a seminar with members of an organization) does not envisage production goals and at the same time offers rules of play that make the relationship itself possible: the *time and place* of the encounter, the *conditions of work* (couch and armchair for the psychoanalysis session, chairs in a circle for a group or a seminar), the *modes of participation* in the session (the psychoanalysts silence; the summary of the aims of the session, in the case of a psychosocial intervention), the modes of *payment* that the participants in the relationship know. While there is the absence of a shared transformational goal which concerns something else and justifies the relationship (learning at school, producing a medical diagnosis, prognosis and therapy in hospital or in the doctor-patient relationship in the consulting room, planning a building in an architect's office), at the same time there are strict rules of play that organize the conditions of the relationship. It can therefore be understood that in a psychological relationship, two contrasting attitudes are constantly possible: the acted out expression of emotions on the one hand, and the blind submission to the authority controlling the rules of play on the other. In the 1970s, for example, during a T-Group, the participants frequently used to eject the trainer from the group, as an expression of a form of emotionality that wanted to express itself against all forms of expression by authority. Another example: it is well known that in "didactic" analysis, the analyst confuses the role of analyst with that of judge of the analysee's adequacy for analysis; similarly, there is role confusion, in the patient him/herself, between patient and student *sub iudice* concerning admission to official training; all this can often mean a falsification of the analytical experience due to the analysee a-critically following the rules of play laid down by the judging authority. These dynamics of reaction and submission can be found episodically and not institutionally in all clinical psychology experience. When they are present, it is interesting to notice that acted out emotional components such as the acted out submission to authority, *are very rarely reported on*. If they were, the acting out could be analysed and it would lose its institutional sense of, for instance, legitimising the experience or motivating the acting out itself. We must remember that many institutions base their very existence on unexplored, unanalysed acting out of emotions.

It is important, and this is something the report allows, that the process of relating should not be falsified, through the transformation of an episodic event into a dispositional attitude based on the reciprocal collusion concerning the reaction to authority or the submission to a supposedly present authority. While the relationship can be seen as a sequence of episodic events, the report is the tool for the construction of a process (of therapeutic intervention) following a line of development. Obviously the process does not envisage *one* specific line of development, which would be impossible in the psychodynamic approach to psychotherapy or in the clinical psychology intervention; the development is followed along its often unpredictable paths. But the shift from episode to process is possible thanks solely to the report. It seems important to go back to the fact that the relationship and the report are complementary. The report seeks the sense, therefore the continuity within the discontinuity of the relationship. In the relationship the clinical psychologist can "interpret" single events; s/he can therefore make sense of the emotional implications that at different times emerge from the relationship itself, thanks to the affective symbolizations that distinguish it. To paraphrase Freud in "Constructions in analysis" recalled above, the interpretation serves to make sense of episodic events in the relationship, while the report allows a *construction of the process* that can be glimpsed in the sequence of emotionally involving episodes in the relationship. Here then is the definition of the new element that the report makes possible: the *shift from the episodic nature of the sequence of relational events to the construing of a sense of process in the relationship itself*. With the relationship alone one can perpetuate *ad infinitum* the insight concerning emotional episodicity; with the report the psychologist can make hypotheses

about the gestalt resulting from the totality of the episodic components of the relationship. S/he can therefore identify that "extra" element that the construction of the process makes it possible to hypothesize.

2 -The report that the psychologist organizes for him/herself during the treatment

This is a "thinking about" the relationship one is involved in, within the psychotherapeutic work of the treatment. In other words, it concerns organizing what is happening emotionally in the relationship into thought categories, starting from one's own experience but going beyond one's own experience, in order to give it a relational meaning that can identify the outlines of the *process* characterizing the relationship itself. The use of language (written, more than spoken) is important because it enables emotions to be transformed into thoughts about emotions; because it therefore enables one to shift from the experience lived in the relationship to a categorial configuration of experience, on the part of the clinical psychologist. Normally this type of report takes the form of note-taking, writing what happens in the sessions or in the activity of intervention, keeping a journal of one's activity.
What happens in this kind of report?
It is in these reports that known categories are tested and new ones are explored. We can sum up what happens in these reports in the following diagram:



For instance, I might ask myself why I get angry when a patient, during a psychoanalysis session, says she has never taken pleasure in sex, in fact she has never experienced it. Only to add, after I underline "Never experienced….": "Well, not exactly never, because sometimes I have experienced it , and it gave me pleasure. Let's say 10 to 15% of the times I agree to make love, I feel pleasure , I manage to enjoy the experience". In talking to the psychotherapist about the issue of her sexuality, the patient tried to exclude all involvement in such activity, enabling her to continue in the dynamic we can call *"complaining" to the psychotherapist.* For some obscure reason, the patient momentarily stops complaining, recognizing that "sometimes" she can feel involved in a sexual relationship. She can therefore reciprocate the relationship with her partner. But complaining equates to declaring explicitly or implicitly that she is unable to experience any reciprocity in the psychotherapy relationship. The patient by adding "sometimes", therefore recalls that "sometimes" she can also experience reciprocity in the psychotherapy relationship. She also communicates that her experience of reciprocity in the psychotherapy experience is for her comparable to that of making love, which involves two people. The patient's statement therefore refers to the fact that *only sometimes*, according to her, is the psychotherapist able to accept the reciprocity of the relationship; in other words, he is able to accept that the psychotherapy relationship is comparable to sexual intercourse. It is understandable why I got angry at the

addition of that “sometimes”: it is the patient’s rebuke at my emotional “coldness” in the relationship, which she associates with her inability to enjoy sex. It is as if the patient said: “I complain because I can’t enjoy sexuality; but I also complain about your incapacity to experience our therapeutic relationship emotionally in a mutual way, comparable to sexuality”. Hence the sense of complaining is like something insoluble, in that it refers to aspects of the relationship that are desired, but catastrophic at the same time. If the therapist agreed to experience the therapy as if it were a sexual relationship, for her it would be impossible to think, and therefore impossible to continue with the psychotherapy. So complaining concerns an unsatisfied desire, but at the same time a desire that is impossible to satisfy because it destroys a thought that could make sense of the relationship within which she complains.

By writing this report, I have understood the sense of the relationship that I have with this patient and that she has with me. I started to write the report because I feel that the relationship is blocked in an impasse. Now I think that the report gives me some interpretative keys to what is happening in the relationship. It is a relationship where the patient’s sexual coldness is compared by her to the empathic coldness of the analyst. It is the recognition that “sometimes” the patient feels pleasure in making love, and it is also a request that the analyst let himself go, even just sometimes, to such an emotional closeness. It is a request to give up the analysis of the matters of the analytic relationship, even if it is emotionally thought, so as to achieve a reciprocal, acted out closeness, totally comparable to the sexual act. It is obviously a pretext, that of being able to have the analyst entangled in a relationship of closeness where the thought out function is lost and where one abandons oneself to the reciprocity of desire and emotional acting out.

I hope it is clear that the report does not concern the patient’s personal characteristics, or her psychopathological or personality characteristics, and nor does it concern my characteristics. What one can understand from this brief report, considering the relational aspect, is the motive that led the patient to ask for and to experience psychotherapy. But an understanding of the patient’s problems would call for a review of the “history” of her therapy and of the emotional connotations of her relationship with me. This is a patient who has never had a symmetrical relationship where one of the participants is not involved in fantasies of domination and control over the other. Hence her agreeing to carry out the psychoanalysis; but at the same time with the fantasy of controlling the analyst, forcing him into a relationship in which the function of thinking emotions is denied.

At this point I can list the relational categories I used in the report:

- the *anger* aroused in me by the “sometimes” sequence;
- the patient’s *complaining*, as the way of structuring the relationship with me. Here the category should refer to the tree of neo-emotions;
- the *acted out reciprocity* in the sexual relationship, differing from the *thought reciprocity* that may underlie some moments of the therapeutic relationship. This leads to the issue of *collusion* and of the different ways of colluding in the therapeutic relationship. But also to the distinction between *acting without thinking and thinking what one acts out*, which is fundamental to the collusive process;
- the *impotence* to which the relationship leads, when one complains about something that does not happen in the relationship, at the same time conveying that if the thing happened it would be a catastrophe for the relationship itself; therefore the *ambivalent* component that always characterizes the dimension of impotence in the relationship.

Why?

Well, when the patient says: “I have never taken pleasure in sex”, she is manifesting, on the analyst’s couch, one of her fantasies; she is talking about her fantasy concerning both the psychotherapy and her way of having sex: a fantasy that compares analysis to her sexual relationship. It is a fantasy where the other does not exist, where she can remain closed inside her identification with her fantasies, outside any relation with reality, and therefore outside any relationship; where the relationship is the necessary, unexcludable dimension for a lived relation with reality. We know that, in psychoanalytic theory, reality can be compared to the symbolic emotional experience through which one enters into contact with objects, which, independently of their “objective” nature, are transformed by symbolization into emotional interlocutors. But in the same psychoanalytic theory, reality is also the test of our fantasies, which comes from the relation with otherness. For the patient, not feeling sexual pleasure equals stating that *the only object she emotionally symbolizes is herself*. The utterance “sometimes I have felt sexual pleasure”, therefore

means acknowledging that sometimes she manages to emotionally symbolize the other: it is as if a breach were opened in the wall made by the exclusive emotional symbolization of herself. This means that even if it is just for a moment, doubt is cast on the emotional conviction that her fantasies, ie what the patient feels emotionally, coincide with reality, or rather, *are* reality, beyond all doubt and with no possible way of testing it.
This breach, on the other hand, seems to be tied to the collusive agreement, by the analyst, of living out a non-thought reciprocity, the type of reciprocity that one must necessarily experience in the "sexual relationship", where the term *relationship* is in close connection with a reciprocal emotional acting out, which is not thought. This is a first step, as it were. But it is a first step that calls for an a-critical collusive participation by the therapist, where he gives up the function of thinking in the relationship. It is therefore a challenge to the very role of analytic work. This is what, in later more thorough versions of this report, I suggested calling *unanalyzable empathic expectation*: the expectation of patients coming from specific cultures, the main one of which, in my experience, is psychology, to obtain from the analyst an emotional closeness, a warmth, an unconditional, a-critical affection that often leads to the interruption of the analysis or the psychotherapy, when the demand is found to be impossible to fulfil. It is in fact an expectation: a demand that one feels is justified by one's role of "patient", of a person in difficulty, lacking affection; a demand which the therapist "must" answer satisfactorily; a demand which, as in the report just presented, entails giving up all function of analysis in the relationship. The patient in the report was able to accept the construction of the meaning of her demand, and continued her analysis fruitfully; in other cases, the same demand led to the experience being abandoned. But we will discuss this more in the last section of this article.
One question remains: does my report, though brief, have a narrative component, even though the categories used have long been part of my way of construing a theory of relating? If you like, does this report retain a narrative structure, even within the new categories that its drafting made it possible to elaborate? This question obviously does not concern the private use of this report, but the public use that I am making of it, since the present article sets out to deal with theoretical hypotheses on the report, to be read by others interested in the issue.

3 -The report offered by the psychologist to the other (client), during the therapeutic relationship

This concerns interpretation, or rather, what the analyst offers the patient, in an analysis, in the form of "construing an analysis". But it also concerns all the reports that accompany and support psychosocial intervention. Verbal reports during the intervention; but also written reports, in the form of documents of reflections that the clinical psychologist offers the client who asked for the the intervention while work is underway.

3.1.Interpretation

An example of an act of interpretative report may be a patient who (in his/her second year of analysis) during a session recounts the following dream: "I was in the analyst's room, but not on the couch; we were sitting comfortably on a very nice sofa where one could sit comfortably (not that the sofa here on the other side of the room from the couch isn't comfortable; but in the one in the dream one could "sprawl out""). I told her I was very happy with my analysis. Then she changed into my father, and asked me if the analyst still had her rooms in the same building where she has her house and where she lives. I answered yes. Then my father, laughing at the situation, told me to tell the analyst that it was time she understood that the consulting rooms, for a question of prestige and decency, had to be in a separate place from the family dwelling".
It should be said immediately that the patient is an oculist in private practice. Two other points should be added: the first is that the patient came to analysis because of some of his sexual acting out, in his professional work, with two women who were his patients. This greatly frightened him; he came to me because he had heard of my rigour towards acting out which according to him, distinguishes my therapeutic activity and my university teaching. The second thing, which now seems obvious, is that the patient has his consulting rooms in a neighbourhood a long way from where he lives with his family.

The patient's father is a strange person, very affectionate towards his family, even exaggeratedly so: recently, for instance, he made a car trip from Catanzaro to Val d'Aosta to take some money to a son (the patient's brother) whose wallet had been stolen during a holiday. The patient adds that the father could easily have sent a money order, but he's like that: when someone needs him, he moves without thinking twice. The father on the other hand is also a person who makes a shady living, basing his activity on ripping others off, selling them all sorts of rubbish. For this reason he has had problems with the law and has been reported to the police various times.
Let me add, finally, that the emotion characterizing the patient's view of his therapeutic relationship is *diffidence* towards the analyst.
He remembers, associatively, that the night of his dream coincided with the day after the analyst had brought forward a session, because he had to go to a conference in another city. But it also coincided with his hearing that his father was in town (not in the town in the South of Italy where he lives for long periods with his wife) for a meeting in court where he intended to carry out a small extortion at the expense of a city organization. The patient had felt ashamed of his father when he heard this.
It should also be added that in a bookshop the patient recently "discovered" some books written by the analyst and he is reading them with great fervour and interest. He says repeatedly that reading books seems to take the place of the analytic relationship; he learns more from reading than from the sessions.
The interpretation-report concerns the "relational" meaning of the dream, where a reified split is made between family affects and the emotionality involved in the psychoanalysis. The analyst *must* keep the emotionality for his family quite separate from the emotionality involved in his psychotherapy relationship. This enables him not to experience the emotional acting out of his professional relationship as a problem for the family emotionality. What is acted out in the profession is not a betrayal of his own loyalty towards his family.
In this sense the "rigidity" the patient attributes to the analyst is critically present in the dream, through the analyst's transformation into the patient's father. With the analyst, the analysis is going well because it helps to integrate the two forms of emotionality (or rather the emotional split that the patient experiences in his professional work); with his cheating father-analyst, the analysis is highly open to criticism because it encourages the healing of the emotional split, and there is the underlining of the stupidity, lack of prestige and social status of whoever integrates the two emotionalities and therefore prevents work as a doctor from becoming the place to act out the sexual power attributed to the doctor by his patients, especially if they are attractive.
I hope that it is clear that in this case, too, the interpretation-report concerns the relationship, and not the characteristics of the patient's inner world. It is certainly an interpretation of transference, but not only this. One has to see how the dream prefigures a specific ambivalence towards the therapeutic relationship. Diffidence, which is the leitmotiv of the analysis, can be understood as a neo-emotion where *the friend (friend by definition) is asked to give a justification of being a friend*. *That is, of not being an enemy.* Let us look at this: the patient comes to therapy to deal with the problem, which he feels is pressing, of his emotional acting out in the professional relationship with his patients. When he asks to enter analysis, he also says that he feels his sexual acting out is a problem, especially in terms of his relationship with his wife and five-year-old daughter. He makes a specific demand in this sense, and configures the analyst as a friend precisely because he gives him the certainty that in the analyst, with his theoretical and also public experience, he can find a witness of this principle of not acting in the relationship with patients. The analyst is a friend, because he is a "living" witness of what the patient wants to become. But he is also an enemy, and for the same reasons: the intransigence perceived in the analyst makes him feel his acting out in the professional relationship to be even more problematic, and several times it crosses the patient's mind to suspect that the intransigence attributed to the analyst is not really so true and constant. With the dream, the patient comes out into the open: it is the analyst-friend who, as a father willing to sacrifice himself for his family, invites him to look critically at this integration of the emotional split. The analyst-integrator is placed under accusation for this very same integrative function, and he is asked to confute the hypothesis that this is all just an unprestigious, "provincial" thing, typical of those who are unable to live the good life and to exploit the power that the profession offers them. It could also be said that the patient came to therapy in order to have an analyst that would reprimand him for his deviant acting-out and bring him back onto the straight

and narrow; this reprimanding function attributed to the analyst is the same that transforms friend into enemy. And so the analysis that "goes well" – i.e. that results in the interruption of the sexual acting out– is also the analysis that "goes badly" in that it prohibits and constrains the *desired* but *repressed* acting out of the sexual power associated with a doctor's position.

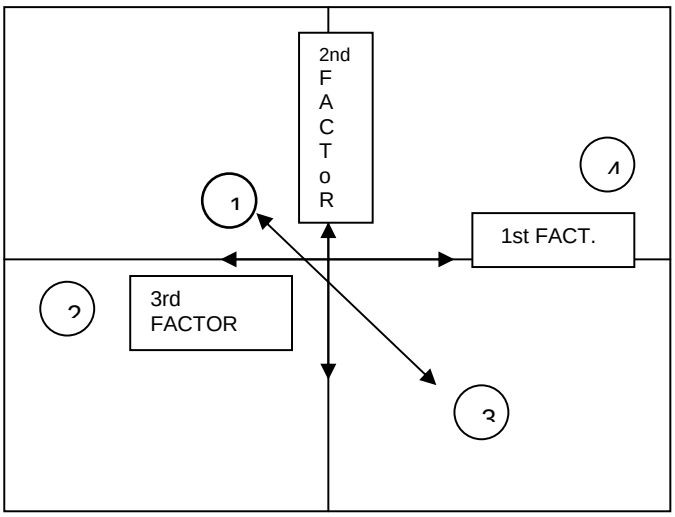
The difference between the previous report and the latter lies above all in the *communicative function* that the second report performs in the psychotherapy relationship. Here the report that the analyst offers the patient, starting from the dream, is a synthesis of the emotional situation of the therapeutic relationship, and therefore a sort of invitation to examine the split characterizing the relationship itself and the nature of the diffidence that characterizes it. What must be stressed is the *process* characterizing the relationship, starting from an episodic event like the recounting of a dream. The efficacy of the report must be tested in the relationship, on the basis of the emotional responses the patient will bring to the analytic process and of any possible changes in the relationship itself.

3.2. The report of an intervention: the psychologists of the Psychiatric Service of Diagnosis and Care/ Servizio Psichiatrico di Diagnosi e Cura (SPDC)

Let us look at another example: here the report concerns reflection on the psychologist's role in the Psychiatric Services of Diagnosis and Care (SPDC). I carried out this activity with several psychologists working for the SPDC in Rome and Lazio. Their request sprang from the need for discussion among professionals who have no contact with each other, each of whom is enclosed in his/her own Service, with a variety of roles, with varying degrees of satisfaction depending on what the Head of the Service requires of them. What characterizes the request therefore is the need to meet each other; these meetings were possible since they were also meeting with me. At the same time, there was the hope that a sort of committee might be formed to coordinate psychological experiences within the SPDC, aiming to achieve a definition of the role of psychology. This committee would spring not from the "goodness" of the Head, but from the competence and aspirations of the psychologists themselves. This request was accompanied by organizational effort which led to two conferences, firstly of the Lazio SPDC psychologists and later at national level. In the context of this work, I organize periodical meetings with the group of psychologists, about fifteen in all, and suggest analysing their local culture by means of focus groups where they can talk and, four at a time, debate the function of the psychologist in the SPDC and how the Service is represented within the group in question.
The research and a report on the work carried out was summed up in a paper I read at the Conference of psychologists in Italian SPDCs, in June 2007. Here is the text of this report.

Psychological thought in institutional, cultural and organizational models
A couple of years ago, a group of psychologists who work in the SPDCs in the Rome area asked to discuss their experience with me and to produce a reflection on the possible lines of development of the psychology profession within the Psychiatric Services for Diagnosis and Care.
In the intervening period we have had several meetings where we have been able to analyse different experiences, where some emblematic critical events have been identified, viewpoints and models underlying professional action have been compared. These meetings were useful for us university psychologists who need to know the different contexts where psychologists work if we are to orient the training of the students attending our faculties towards aspects of professional reality and not merely to the idiosyncratic experience of single professors or to their chosen models. I hope these meetings have also been useful for the colleagues involved and for their work.
During the activity of reflection, focus groups were held in which groups of four SPDC psychologists talked about their work, about the function of psychology in the Service, and of the problems encountered. The focus groups proceedings were recorded and transcribed. On the texts obtained, after a process of disambiguation and preparation, the Emotional Analysis of the Text

(AET) was carried out[2]. What emerged was a cultural space with four clusters of dense words (words with high polysemy and low ambiguity, significant for the analysis of the collusive culture found throughout the text).
Let us see the synthesis of the cultural space:



On the first factor there is a contrast between cluster 2 and cluster 4

Cluster 4, which we will see serving as the pole of attraction also for the second factor, underlies a representation of the SPDC as the cultural side of psychiatry, evidently as it is culturally organized by the psychologists: it deals with the *gravity of mental illness*. Grave, from the Latin *gravis*, has the basic root *gar* meaning weight. Grave, therefore, like weighty, difficult to bear (it is interesting that soon afterwards, in the ranking of dense words, there appears the word *weighty*). It therefore seems that the oft repeated "gravity" of mental illness that causes crises, is in fact a description conveying more the attitude of the doctor, or rather, of the context (difficult to bear), than a diagnostic state specific to a pathological form. Grave mental illness is in fact *schizophrenia*; but also *bipolar disorder*. Two interesting dense words follow: *cure* and *incurable*. Exactly, one tries to cure something that is defined as incurable, so one is setting oneself an impossible task. This paradox is partly corrected by the verbs that follow, *know* and *integrate*, which lead back to the aim of reintroducing the serious patient into the social context s/he belongs to, avoiding *prison*, overcoming *delirium,* bringing him/her away from *death*. The goal of coping with grave illness leads to favouring the technician of this problem, the psychiatrist, and the tools that the psychiatrist can use, i.e. medication, or rather *psychomedication*. It is therefore understandable that the second most important dense word in the cluster is *medicine*, with the contradictions that psychiatry experiences in the culture and in the medical world.
In short, this first cultural component seems to underline the fundamental elements in psychiatric operation: grave mental illness. Once we have entered this viewpoint, what is stressed is the profound uncertainty of those who are concerned with this phenomenology: on the one hand the certainty of medicine and the cure; on the other the incurability, and death. A compromise between the two sides of the problem seems to be the reintegration of the seriously ill patient, i.e. his "being

[2] For a description of the AET, see: Carli & Paniccia, 2002.

returned" to the same context in which the crisis that led to the hospitalization occurred. Apart from the individual approach, aimed at defining the illness serious, other solutions are offered besides treatment: for instance the analysis of the causes that led to the crisis, research into what features of social relations facilitated the transgressive manifestations of the "patient", but also a thorough examination of the context in which the crisis came about.
Let us briefly return to the idea of "gravity", referring to mental illness.
More and more often we hear talk about the gravely ill, about serious forms that are dealt with and "cared for" in various facilities and services of Mental Health. We also hear it stressed that some forms of psychotherapy are more suited than others for "grave" psychopathologies. It would be useful, in our opinion, to think more deeply about the idea of gravity, as it is used in medicine. There is one criterion and one alone to define gravity in medicine: the irreversibility of the pathology, and therefore the scarce probability of success in the therapeutic intervention; gravity, in medicine, refers only to the outcome of the pathology *quoad vitam*. One has a grave illness because an etiopathogenetic therapy of the same form is unknown; there are clinically grave patients because the illness (though it can be treated) is found in a highly problematic clinical situation, due to the co-occurrence of other pathogenic forms, due to the patient's general physical conditions, advanced age, reduced immune defences etc. What is the criterion of gravity in the so-called psychic illnesses? Our hypothesis is that the definition of gravity concerns an attitude of "concern": when there is gravity, there is also the need for high level competence: when the going gets tough, the tough get going. Remember that the idea of "gravity" was the favourite weapon for the press and the opinion-makers of the mass media in the 1970s and '80s, against psychologists. Extreme concern was shown in deploring the idea that "grave" patients were entrusted to people with questionable training, claiming to exercise a profession that was the domain purely of psychiatrists on the one hand, and psychoanalysts on the other.
We believe, instead, that in order to define "gravity" one must use a criterion that takes into account the potentialities for development of the person with the problem, in his/her context. In fact, it seems that "grave" cases, in the sphere of Mental Health, are those in which the only treatment possible concerns psychofarmacology, on the one hand; on the other hand, urging, or at times even forcing the structures that have a relationship with the "patient" to accept him: the family, the neighbourhood, the building, the street, sometimes the place of work or study. In other words, those cases in which it is not thought possible that there will be an autonomous development of the individual in the social system of which he is part. If this criterion is true, then it is clear how false it is to consider, as is commonly implied, that *gravity* equates to the *difficulty* of the case. If our hypothesis applies, the "grave" cases are certainly not the most difficult ones: it is more difficult to intervene in favour of the development of the person in the context than to facilitate temporary, unstable adaptations of people with no hope of development, in a context that one hopes is accepting and capable of supporting the patient-outsider. But, if we look closely, also the "grave" cases can and must benefit from an intervention for development: this concerns the *development of the symbolic emotional system supporting the social adjustment of the mentally ill themselves*. If we look to the recent past of psychiatry and consider the guilt-inducing strategy of the psychiatrists who wanted to "impose" the patient on the most varied social systems, primarily on the family, stigmatizing the violence of their refusal and of their "buck-passing" to psychiatry, the naivety and at the same time the "violence" of this type of intervention makes us smile. Since guilt-inducement has been replaced by a real attempt to create development in contexts where mental illness is contained, we are witnessing first hand the difficulty of this intervention and the need for a *theory of social ties* to establish the efficacy of the intervention itself.
Returning to our emotional analysis of the text, it is interesting to notice that this first cultural component makes no reference to psychology, to the function of psychology, to the role of the psychologist. It seems to express a sort of extraneousness of the role that the psychologist can play in the SPDC, a feeling of alienation that can only be elaborated with the identification of the psychologist with the psychiatrist, with the disastrous consequences for our professional identity that such an identification can entail.

Cluster 2 is opposed to cluster 4 and one can therefore envisage the appearance of the psychological function in the culture that the grouping of dense words suggests. The four dense words that refer to the psychological function are: *medical record, assessment, diagnosis* and *test*.

The verb supporting the specific performance of psychologists is *propose*. Propose means "leave before". Before whom? The *doctor*, naturally. It is interesting that in this function, associated in the sequence of dense words with the function of *secretary*, the psychologist feels *alone*, in a culture that wants the *patient at the centre* of the concern and interest of those who work in the SPDC. We see the re-appearance of the old diatribe that sees the psychologist, in his/her collaboration with the psychiatrist, as an operator capable of looking for and providing test data to those who later have to make the diagnosis, but above all establish the patient's therapy. In the cultural component we are examining, it seems that the psychological function is in a certain sense ancillary to that of the doctors: a secretarial function of keeping the medical records in order and applying tests. This is a function that sees the patient at the centre of all activity in the unit, therefore favoring that psychiatric specialism that deals with the patient, seen in the individualist dimension, as being "curable" with medication. Every other function of the psychologist seems to be excluded in this culture, or to be relegated to areas that do not appear here.
On the first factor there is therefore a contrast, in the representation of the SPDC, between a psychiatric vision of serious illness and the marginal function of the psychologist's test diagnostics. It seems a sort of *ancien régime* representation, typical of the psychiatry of the 1950s and '60s, where one often heard talk about testing as the only possible contribution for the psychologists in the Psychiatric Hospital. This belief really seems hard to eradicate, even in the representation of the psychologists themselves.

On the second factor cluster 4 is in contrast with cluster 3.
As we have already said, cluster 4 concerns a person suffering from a grave mental illness.

Cluster 3 is very interesting since it represents a heroic cultural and at the same time human reaction of the psychologist to mental illness: there is talk of the *violence* of the mentally ill person, who can go so far as to *attack* the psychologist and *hurt* him/her, even sending him/her to *Emergency.* The psychologist can oppose *contention* and pursue an *open-door* policy, but this can have unpleasant consequences. There is talk about the daily life in the division, experienced only by *nurses* and *psychologists,* a daily life made up of *attacks of anger*, of violent outbursts where the psychologist finds him/herself *racing* around the division, *running away*, in search of help from *nurses* that are stronger and better trained to cope with violent patients. The psychologist feels, at times, *fear* before violence and so can understand the fearful response of family members or the people living with those who, during a psychotic crisis, may threaten to hurt whoever comes near. But also the fear caused by diversity, in behaviour that is unpredictable and incomprehensible within the lines of cultural orientation that usually allow socialization. There emerges, therefore, a slice of life in the division, made up of open-door policy but also of threats and fear. It seems that there is the attempt to stress the difficulty encountered by the psychologist in intervening psychologically in a relational situation where violence, threats and physical attacks are always waiting in the wings, where the danger of suffering an aggressive attack is always possible and hard to predict. Where, in other words, diversity and alienation prevent the relationship of dependence that underlies, in so many other fields, the psychologist's professional intervention. In the SPDC, the setting is not a given, but has to be constructed by relating and by relating in the right way. The setting, when one considers it closely, is never a given; but in the SPDC this is particularly clear and disquieting.

On the third factor, cluster 3, concerning violence and evil, is in contrast with cluster 1, which we will now look at.

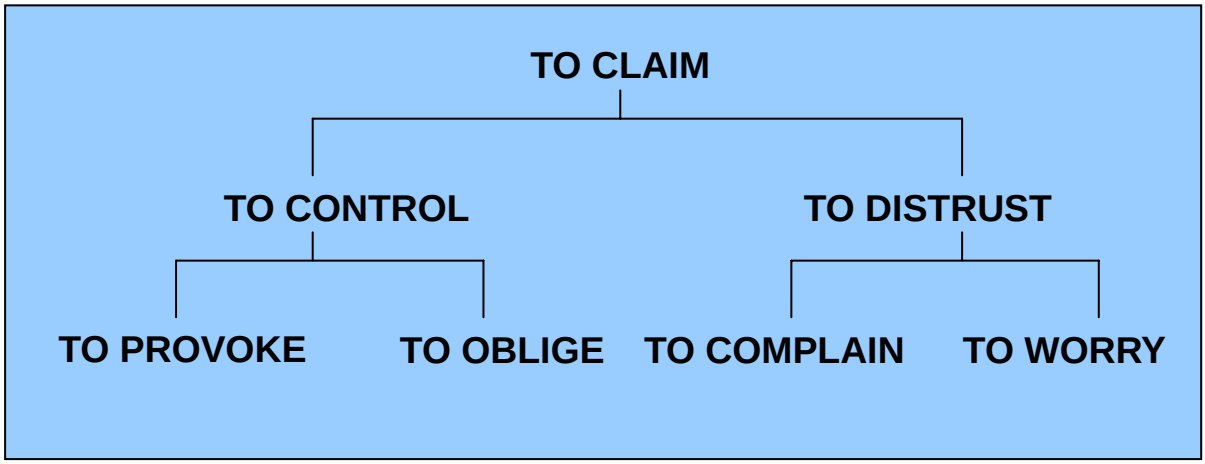
Cluster 1, in its first dense word, talks about *project*: from the Latin *pro* and *iacio,* meaning throw forward, advance. The project pitts the person speaking against the future, against a bet about the future, not against the past or the present locked in on itself. In the cluster there is also talk about the past: *loss*, *crisis*, *admission*. The *human* problems that caused the crisis can be seen, as can the the links with the *local area.* The tribulations of the patient in hospital are discussed, connected to the context of living together and in particular to the *family.* Emphasis is placed on the importance, at the moment of admission to hospital, of the phase of *reception where* it is possible to organise a project that can orient the *psychotherapy.*

It is important to underline that in the cluster, there are no medicalized words, but rather events or emotions that make sense only if they are analysed using clinical psychology reference models. The setting of the crisis is certainly the family, but also the local area of the person who has been put into hospital. The critical event seems to be linked to a loss, a loss of affects, of security, of comforting ties, of protection and reassurance. Loss always entails a tie, a relationship; it is within a relationship of possession that one loses, and experiences the crisis associated with loss. It is through reception, in the two senses of place where one's hospital admission begins and of welcoming behaviour, that it is possible to transform loss into hope, and therefore into a project. And it is interesting that the dense word *psychotherapy* is found in this cluster, where there is no talk of patient, seriousness, violence, diagnosis, treatment and medication; where there is no talk of psychiatry or of medicine.
As we can see, it concerns a local culture (emerging from the Emotional Textual Analysis of the focus groups) that is complex and very varied.
On the first factor there is the contrast between the psychologist's diagnostic, or rather textist, function and the psychiatric function totally centred on the seriously mentally ill patient and his/her cure/incurability.
On the second factor there is the contrast between the the official psychiatric function and life in the division, made up of fear of the threats towards the psychologists and nurses, of punches received, of restraints as the remedy to the open-door policy, which collides with the obstacle of the patients' anger and unexpected and unpredictable outbursts of rage.
On the third factor there appears the psychotherapy project, oriented not by the diagnosis but by the knowledge of the events that led to the crisis and the admission, oriented by the act of receiving the patient and by understanding.
The psychological function is outlined, albeit very discontinuously, on the third factor, and it is closely connected to psychotherapy. It is a function that contradicts the stereotyped expectations of a psychologist modelled in imitation of the psychiatrist, of a psychologist experienced in tests and in psychodiagnosis ancillary to the doctor, of a psychologist afraid of the violence of mental illness.
The psychological function, cluster 1 seems to tell us, develops fully only if it is clearly *differentiated* - both at the level of the models adopted to interpret and analyse the reality of the SPDC and at the level of intervention methodology - by other models, first of all the model underlying psychiatric practice.

Let us now try to pass from the local culture of the psychologists participating in the study, to some hypotheses on the professional role theat psychologists can play in the SPDC.
This service, remember, has the task of dealing with the crises of accepting hospitalization suffered by the person believed responsible for the crisis, i.e. the mentally ill patient.
One usually talks about a 'crisis' as the situation causing the admission of the psychiatric pathology to the Service. Why 'crisis'? I would like to look more closely at this term and at the phenomenology underlying it.
Crisis, noun deriving from the Latin "*crisis*", in turn from the Greek "*crinò*" (I judge). It means choice, decision, and culminating moment of an illness. Crisis, therefore as a decision, a behavioural communication of a choice within a relationship.
This is an event connected to a relationship, and it comes from the same *rationale* as law n° 180: adapt mentally ill people to the context in which they live with others. *The crisis, therefore, is seen as the moment of difficult adaptation to the context.* What does this mean? It means that the context does not tolerate or accept a specific behaviour on the part of the individual, in that relational context, because it is a sign of the breaking of the rules of living together. The crisis therefore has to do with the rules of living together and with the expectations of respect for the rules themselves.
We could talk at length about violations of the rules of the game. It is the individualist model that underlies the interpretation of this phenomenon. This model, in parallel with juridical models, sees a violation of the rules of play as being the responsibility of a single individual or single individuals. Single individuals are somehow reassuring: the individual can be identified, his responsibility can be assessed, it can be decided whether the violation committed was done involuntarily, unintentionally, or intentionally, or whether it is related to states of mental incapacity. This is the

line separating, though with some epistemological difficulty, juridical responsibility from the non-responsibility of mental illness.
At the bottom of the crisis, on the other hand, there is not a single individual, either deviant or ill. *At the bottom of the crisis there is the failure of a collusive system that governs living together.*
Without this failure of collusion there is no criminal act, just as there is no mental illness.
The diagnosis, the definition of the individual or of his actions come *afterwards,* and are a direct consequence of the crisis. They can also be invoked as the cause of the crisis: "that person did all this because …". But they are not strictly related to the crisis. If this close relationship were possible, it would be feasible to predict the crisis, thus giving the possibility of a real, effective prevention. But it is not possible, at least within certain limits, to foresee a crisis, because the crisis is not an individual event, but a *social event* concerning the relationship between people in a context.
It is interesting to notice that neither the law nor psychiatry have operative models that can make hypotheses and interpret relational events. The reconstruction of the crisis, therefore, always takes place "post hoc, ergo propter hoc".
It is interesting that psychiatry treats the crisis as an event for which a single individual is responsible, i.e. the mentally ill person. The SPDC is the mirror of this *vision* of the crisis event. Hospitalization is the fault of the protagonist of the crisis, while the various deuteragonists are involved only as "allies", by default, of the doctor treating the patient. When "the reasons" for the crisis are asked, this is done only to discover the outlines of the critical response, to get a sketchy idea of what factors set it off, as they appeared to be in the life of the protagonist.
Why? The reason lies in the fact that psychiatry, like the law, has no models to read and understand the events concerning relationships. In pointing this out, I do not mean to criticise psychiatry, which uses models and categories that are very useful in dealing with the psychotic crisis, in sedating a mentally ill patient, in making possible his/her reinsertion into the context. What I am underlining is that although this vision of mental illness is effective, it is partial. It looks at only one aspect of the phenomenon and necessarily neglects others, which in my view are very important precisely in the intervention on the crisis.
Think for instance of the family, of the family system as the scale of relationships. Think of the people living nearby, of questions concerning the next door neighbours. In the two cases, we are dealing with social dimensions that *have no productive aims*, in the transformational sense that is usually associated with the idea of production. What is the difference between productive aspects on the one hand, and non-productive social situations on the other?
We will apply an idea from clinical psychology to this. In productive relational situations, the relationships are emotionally oriented towards a "third thing", the product in the sense of the transformational dimension of an aspect of reality that does not concern the relationship itself, which is *external* to the productive relationship*.* If, for instance, five architects in a "group studio" discuss how to draw up the plan for a house in the mountains, for a client who would like an unusual, creative solution, the aim of the relationship between the five architects is the design of the house in the mountains, in line with the commission received and accepted. Certainly, in the group of architects there may be differences of opinion, even clashes, alliances of some in opposition to others and changes of mind, but the relationship will always have the house design as its sole objective. If the attention shifts from the plan to the individuals, if the conflict concerns not the plan but the relationship between the individual architects, *the productive function of the working group risks collapsing*. If one of the five architects goes so far as to blame the others saying, "You four always gang up and reject all my suggestions!", the group will have to make a great effort to solve the problems connected to the internal problems, and it will only be able to devote the few remaining resources to carrying out the project. The emotional symbolizations that structure the working group must be useful to the project, otherwise the relationship will be dysfunctional. When working groups pay more attention to the symbolizations with which the various members experience the relationship, losing sight of the "third" object of their work, the problems become serious. Let us say that, in groups used to working together, *concentrating on the third thing* is a highly observed function and usually leads to a successful group outcome.
This means that the emotional symbolizations with which the different members of the group represent themselves and their companions in the group, are always oriented to the specific function which brought them together. Roles can, or must, be differentiated, but this also means

that in terms of their role and their competence, all of them contribute to the success of the project, to the achievement of the third thing.
I have dwelt on this aspect of the working groups for two reasons.
The first reason concerns a description of the relations that are set up when the system of relations is an “end in itself”, i.e. there is no third thing to achieve. As we have said, this is the case of family systems or neighbourhood groups, which are also the places where the psychiatric crisis most often occurs. The lack of a third thing, in other words the lack of an objective of transformation outside the relationships, means, in family systems, that the orientation of relationships is totally self-referential. Hence the difficulty of exchanging, and the almost total focus of the relationships on the question of possession.
Let me recall the tree of neo-emotions: ways in which one expresses the propension to possess the other in a relationship.



Possessing the other means *making demands on* him/her, in the name of the role played in the relationship (you must love me, I am your mother); it means *controlling* the other, i.e. asking the friend to prove that he is a real friend, inviting him to face an impossible test; it means *distrusting*, i.e. living in a perennial situation of alarm for an imminent danger, where the other is seen as the object of one’s delerium; it means *provoking*, i.e. imposing one’s own personal and often secret rules of play, instead of shared rules; it means *obliging*, i.e. blackmailing the other with the listing of the obligations one has always honoured, presenting oneself as the victim that obliges in the name of his own sacrifice; it means *complaining*, i.e. involving a third party so as to re-establish the phantasmic relationship that one feels is threatened, with the person about whom one is complaining to the third party; it means *worrying*, again calling in a third person so that s/he will intervene with the one who no longer satisfies the expectations of the complainer. Just think of what emotional pressure weighs down a person who lives exclusively and daily, in a relationship pervaded by all these neo-emotional dynamics. These dynamics, as we have said, pervade both family life and that of the neighbourhood, all the relational situations that are not characterized by the production of a transformation of aspects of reality; such a transformation is based on a specific commission and on a precise organizational process, structurally defined according to roles and functions. When the definition of roles and functions, each person can be given the most varied roles, and can, of his/her own initiative, assume yet other roles. This uncertainty of roles can exert very strong emotional pressures, becoming almost unbearable; think of a mother who expects affection from her son and who forces him, paradoxically, to express *dutiful feelings of love*. Think of a family that feels talked about by others in the building, due to the concern with which another family in the same block regards them (is one of their children homosexual? How does the pretty second-eldest girl earn a living, the one who is always with a different boy? And so on). Think of the constant fluctuation between the role of friend and that of enemy that one

undergoes if one is subjected to diffidence and control in one's social relations. We could go on and on.
It is within these sorts of emotional acting out that in the vast majority of cases the psychiatric crisis takes place. Such crises are far rarer in social systems based on exchange.
Hence the importance of psychological models that enable the system of relations within which the crisis occurs to be analysed.
A second reason for the interest in the difference between social systems oriented to the production of a third thing and self-referential systems comes from the consideration of the SPDC as an organizational system. Here is a criterion for the analysis of the SPDC. In the relationship between operators and patients, operators and family-members, what prevails are orientations towards production, and therefore focus on the third thing; or are they self-referential organizational systems, where the attention is focused on the emotional symbolizations with which each person experiences the other, through the fantasies that the other evokes? This seems to us to be a major question for the work of maintaining the organization, which is always important but which becomes particularly so in "critical" organizations, since they are subjected to strong emotional pressures in their operation.
We have therefore identified two areas of possible intervention for the psychologist in the SPDC: the area of crisis and that of the organizational functioning of the Service. These areas require specific models for the analysis of the relationship, and also their own methodological models designed to intervene in the relational system.
We know that if the clinical psychology intervention focuses on the relationship, its methodological underpinning is the *suspension of productive action* (or acting out within the emotional system), with the aim of promoting a *thinking of emotions*, and therefore an awareness, effective though approximate, of the emotions acted out. We also know that among the varied and eclectic senses of the "group", there is one that is relevant to us: the group as a set of people who usually live out a relational experience (a family, a group of neighbours, the component of an organization, the assembly of an entire organization, size permitting) and that are brought together in a setting that envisages the suspension of acting out or of productive action, to think about the relations that characterize the people themselves. It is a group therefore as the context in which thinking of emotions is facilitated. These emotions usually characterize the acting out of the system of people gathered together or the organization in which the people work. In this sense one can act as a "group" with the set of family members or neighbours that make up the shared place of the crisis which led to the person's admission to the SPDC. The group in this case aims to reconstruct the possible emotional dynamics that caused the crisis. This reconstruction is important for two reasons: to provide orientation for the intervention project for the person admitted to the facility; to lay the basis for an intervention of return to the context and of prevention of other possible crises.
The operators in a SPDC are also a group, aimed at maintaining the emotional dynamics underlying the working of the Service. It therefore aims to analyse the emotional responses evoked, in the different operators, by the relationship with the patients or family members, to understand its meaning and to channel its therapeutic value. Remember that in a context like the SPDC, every act by each operator can assume a therapeutic or a non-therapeutic value not only towards the individual patients but also for the whole system.
The psychologist also has the role of recording and analysing *critical events*. By critical events we mean an organizational event (the behaviour of a single person or of a group; the emergence of unusual or unexpected relationships; the explosion of conflicts; the appearance of contingent modalities of organizational functioning, different from those foreseen) which has the power to reveal and underline the collusive emotional phenomenology that characterizes that organization in a particular moment in time. The critical event therefore has a great *revealing* power concerning processes and dynamics characterizing the organization. The focus on critical events and the ability to interpret their meaning is a fundamental part of organizational competence. From the angle we adopt, the critical event represents the organizational manifestation of a *collusion failure.*
An example of a critical event?
Shall we ask what difference there is between an SPDC and an old psychiatric hospital?
Time seems to be the most important element of difference: in the Psychiatric Hospital a mental patient's stay could last forever, so the P.H. clearly had a *custodial* role, "eliminating" the mentally ill person from the system of coexistence (within which the failure of collusion in coexistence

occurs, which is then diagnosed as mental illness). In the SPDC, however, the law establishes a *time limit* for a patient's stay; a very short time, if one thinks of the years that stays in the Psychiatric Hospital lasted..
And it is interesting that the most evident violation of what is prescribed for the SPDC concerns the time of stay: there are patients who are kept in SPDCs for years. This is a sort of skeleton in the cupboard which appears to be the outcome of the collusion between politicians and psychiatrists: politicians who impose an extended stay, prolonged for years, to discredit the political act of the closure of Psychiatric Hospitals; psychiatrists who passively accept (?) the will of the politicians. However, in this acceptance; they also express their conviction about the irreversible nature of mental illness, but above all about the "social" and "family" genesis of mental illness itself: there are cases where, thanks to the support of the politician of the moment, a family manages to have its "sick" member taken away, i.e. the family member who frightens, threatens, assails, makes it impossible to live together in the family, in the context they belong to, the building, the neighbourhood. These prolonged stays are, from the viewpoint we are proposing, a critical event. With their presence, they show the failure of the collusion that supports the very existence of the SPDC. They represent a sort of *memento mori* for all the inmates, reminding each of them of the falsity of the supposed reversibility of the crisis, the rejection by the social and family system of their return to their context, the uncontrollable violence of the illness and the impotence of those who are supposed to be treating him.
Critical events can be conflicts between doctors, or between doctors and nurses; a critical event can be the use the Service proposes to make of the figure of the psychologist; again, critical events can come from the behaviour of an inmate, from the conflictual relationship between the Service and the patient's family. We talk about conflict because the relational situation underlying the productive organization, and therefore the focus on the third thing, is the assumption of the other as a friend, as an ally in the process of transformation that is planned. Every conflict represents the failure of the collusive process that assumes the other as a friend within the common productive effort. In this sense, the change of the productive system into a family system is a critical event. This is a risk that seems to be clearly present in every SPDC. Now, an important function of the psychologist is that of picking up the symptoms of the critical event and of identifying the best ways of analysing it, so as to facilitate the understanding of the organizational problems signalled by the critical event.
It is clear that the role of the psychologist can be important, certainly difficult, but crucial to the efficiency and efficacy of the Service. These are functions that concern the crisis, the working of the SPDC and the analysis of critical events. There are two essential conditions for the psychological function to be carried out: psychology training designed to provide the basic competence to deal with the above issues; the valorization of this competence on the part of those in charge of the Service. This means constructing the sense of the role of psychology in the SPDC: a sense that is not pre-established, as always happens for psychological competence, but that has to be patiently constructed over years, with professional updating, with the coordination of the profession, with the assumption of a solid identity that makes it possible for those using the medical model in the health service facilities for mental health to stop using *temporary* identities, so as to claim their own professional autonomy. This is the only way integration can be achieved: in order to integrate different realities, it is important for the diversities to be accepted and underlined forcefully; when diversities fade, becoming confused in processes of ambiguous hybridization, integration is replaced by a shift to mortifying subordination, which is no use to the professions involved but, more importantly, no use to the patients of the SPDC, to the working of the facility, and to the expectations that the context holds towards the facility.
This report was used by the group of psychologists commissioning it as the basis of a discussion on the role of psychology in the SPDC, as the inspiration for a national document designed to define and defend the role itself, and as organizer in the clash between experiences in the follow-up to their work with the Clinical Psychology Chair.

4 - The report to the scientific community

A third area of the report concerns the communication of events and thoughts on events to the scientific community.
I will now give an example that I think is important for several reasons.
I will start with a consideration deriving from the experience as an analyst, with patients at times being people working in the field of psychology and psychiatry. I will particularly look at the psychoanalytic problems posed by the "psychologist" patients. Let me say at once that what characterizes such patients is, in my experience, the habit of a-critically considering their own emotions *as if* they were reality.
This happens in particular when emotive fantasies concern the analyst and his/her aspects seen as "negative": coldness, errors in interpreting or construing, the non-credibility of his/her hypotheses; supposed transgressions of the setting, the feeling that s/he is not paying attention to what is said in the session, the certainty that s/he has fallen asleep, harsh responses etc. Expressions like: "I don't feel understood by him/her", or "I don't feel him/her emotionally close to me, s/he is not "empathic", may be frequent and, as we shall see, highly problematic. We know that analytic work entails a double mode of being in a relationship, both for the patient and for the analyst: on the one hand, one experiences emotions, one is caught up by the emotional symbolizations involved in the relationship; on the other, one tries out an emotive thinking of the emotions. The latter component is the one that differentiates the psychoanalytic experience from many other moments in life, where the emotions deriving from affective symbolizations of objects, present in reality, are acted out and not thought. Let me underline that this thinking of the emotions is not exclusive to the psychoanalytic relationship, but it is important for it to characterize the experience itself. From this point of view, we can differentiate those analytic relationships where thinking emotions is possible from those where, for the most varied reasons, it is not possible to think emotions. If this last situation emerges in analysis, the analysis risks being transformed into reciprocally collusive acting out between analyst and patient, which inexorably leads to an impasse and later to a failure of psychotherapeutic collusion. Hence the importance, for the analyst, of not colluding with the "provocations" acted out by the patients, and of being able to wait. The lack of the expected collusion can at times help the patient to ask himself about the ineffectiveness of his provocations, which are usually capable of forcing collusive answers from the interlocutors of his relationships. One may question the sense of equating one's emotional fantasies to reality. Equating these two things prevents any confrontation between one's own emotions and the other, the emotionally characterized interlocutor. Think for instance of a patient who rebukes the psychotherapist for being too strict with him: he expects the patient to lie on the couch, he sits strictly behind the couch itself; why doesn't he sometimes sit in the armchairs in the room, so they can look each other in the eye and have a chat? In this way the analyst could also talk about himself, his own life, his problems (he must have some!) and the relationship would become more friendly and symmetrical. Before interpreting the sense of this fantasy, it is important to understand whether the person offering it is willing to understand what s/he communicated with the fantasy itself. This is often feasible: it may be the patient himself to wonder, smiling, whatever is the meaning of this claim that it should be the analyst that talks about himself and the patient that listens with interest. Other times, this fantasy is presented as a cogent, legitimate need, even going so far as to make the analysis situation (patient on the couch, analyst sitting behind) appear no longer acceptable, the symbol of an intolerable power attributed by the analyst to himself, without understanding the more comprehensible needs of the patient. Think of a patient who during a dinner with friends heard someone who personally knows the analyst criticising him, and asks insistently that the analyst prove his innocence, justify himself and reassure the patient, who has lost faith in the analyst. On top of the request there is the added threat that the patient will break off the psychotherapy if this justification does not arrive or does not seem credible. We know from Strachey (1934) that not knowing the analyst is an important condition to ensure that the patient's fantasies about the analyst are not anchored in explicit dimensions of reality. But it is impossible, in the present situation of analytic work and in particular of analysis with psychologists, for an analyst to be not "known" by the patient. Hence the possible, continuous triggering of fantasies, prompted by multiple elements of reality. The problem, on the other hand, is not that the patient should not be stimulated to produce fantasies about the analyst. Rather, it is to see whether or not such fantasies are thinkable. This is the problem that I have repeatedly found in analytic work with psychologists: the claim that the fantasies about the analyst, like those about other aspects of their

life, are “true”, that they are interchangeable with reality, independently of any feedback that reality itself can give.
What relationship is there between confusing a fantasy with reality and being a psychologist[3]?
I would like to start with an observation by Freud (1937), about the “negative therapeutic reaction”: “When the analysis is subject to the pressure of strong factors that inevitably cause a negative therapeutic reaction, and the guilt feelings, the masochistic need to suffer and the *rebellion against the help that can be gained from the analyst*[4] are so strong, the patient’s behaviour […]” (p.548).
We will come back to the negative therapeutic reaction later; now it seems important to consider the rebellion against the therapist’s help: why should there be a rebellion against this help? The question is particularly useful, if we remember that the patient himself asked for that help; that he explicitly looked for it and stated that he wanted it, despite the “cost” that receiving that help entails. I believe it is important to consider the representation that psychologist-patients offer, with the rejection in question, of the “patient” they are currently impersonating, on the one hand, that they think they will have or already have professionally, on the other. The simplification of this representation of the patient is obvious: it is a person who demands (love, warmth, affective support) from the person who “pays” for this, and that is all. Hence the unanalyzable nature of a demand that has some features that can be regarded ironically:

a – it is a *paradoxical demand*: one cannot obtain warmth and affection by demanding it, without reciprocity. In fact by establishing a negative reciprocity, as if to say, you “owe” me warmth and affection, so I expect you to adopt an attitude of univocal affective support, under threat of a punishment from me if this does not happen.

b – it is *an impossible demand*: the expectation, as we have already underlined, is in fact to set up a therapeutic relationship based on emotional acting out. This acting out does not envisage, and categorically excludes all thought on emotion that is required to substantiate the therapeutic relationship. In this sense, the demand to be loved warmly, as the only content of work and of the therapeutic relationship, inevitably entails the interruption of the therapy (if correctly understood.).

c – it is an *oversimplified demand*: if one follows the example of the demand, in fact, one can understand very clearly what the acted out representation of psychotherapy is in these cases: practising psychotherapy consists of “loving and being warmly emotionally supportive,” for the patient; with no theoretical complications, no technical difficulties, no learning problems, or problems of professional practice, of reflecting on one’s own experience: none of this; all that is needed is to love warmly. The role of the patient is also simplified: no analysis of the problem, of the demand, of the relationship, or if you like, of psychopathology; the patient is a person who demands to be loved, to receive warmth; by paying, incidentally.
It is this latter feature of the demand that can put us on the right road for an understanding of what we are presenting. The patient-psychologist can associate his being in therapy with a sort of duty related to the *ancienne querelle* on the need for those who want to practise psychotherapy to first submit themselves to psychotherapy. The prescription to “submit themselves” to psychotherapy can express the *submission to a rule*: a condition that may preceded a psychologist’s psychotherapy experience or accompany him throughout his professional life. If the patient is a psychologist, moreover, the psychotherapy work can take place on a double level: that of understanding oneself, which psychotherapy makes possible, and that of learning to interpret and construe, which the psychologist may think s/he can “steal” from his own psychotherapist. The latter level can highlight the “distance” in culture and experience between the psychotherapist and the patient-psychologist. The latter can therefore be involved in a confrontation between himself, his own competence and his culture, on the one hand, and the culture and competence of the psychotherapist, on the other. This confrontation can be a spur for the psychologist’s motivation to develop. The confrontation, however, can also have different outcomes: the idealization of the

[3] This does not mean we are arguing that “only” psychologists confuse their fantasies with reality. Instead, we would like to suggest that this problem of confusion, found in some patients, is particularly frequent among psychologists and in their psychotherapy it becomes a particularly serious problem.
[4] My italics.

psychotherapist, on the one hand, and his/her devaluation and deterioration, on the other. It is useful to point out that these are two sides of the same coin, in that idealization exists systematically, sooner or later, in the devaluation of the idealized object. A significant aspect of devaluation can take the form of the demand, unrealizable, to be loved. The need to be loved expresses very well the need for the other, the psychotherapist, to be involved in an impossible task, for the reasons we highlighted above: the unanalyzable demand enables a relationship of exchange to be transformed into a relationship of possession. Whoever demands love, empathy, affective support, and demands that the psychotherapist act collusively in this claim, drains the psychotherapy experience of all competence and cultural depth. S/he transforms the psychotherapist into a hostage of his/her own needs; s/he can evaluate him and find him lacking; and will reach the conclusion that in the end the psychotherapist, with all his competence and experience, is unable to give what the patient wants, the simplest and most important thing in the world, i.e. to love the other. This love is seen by the patient-psychologist as being easy to falsify in psychotherapy. At times the psychotherapist lets himself be corrupted by this demand, and "pretends" warmth, affective support, understanding, love, thus establishing a false relationship with no meaning. The patient-psychologist can then achieve his masterpiece: that of falsifying his own psychotherapy experience, laying the basis for a professional future based on the same falsity established through the identification with the aggressor. When the psychotherapist does not collude with the unanalyzable demand, by offering interpretative hypotheses that make sense of the situation of impasse, he may see his attempt at understanding laughed at, along with his work designed to implement thought about the emotions that make up the demand. These attacks often target the psychotherapist's inability to get emotionally involved in the psychotherapy, to abandon his rational attitude so as to finally understand what the patient-psychologist is really asking. The psychotherapy experience thus moves rapidly towards a breakdown.

The unanalyzable demand is a historically situated, culturally characterized phenomenon. If one thinks of university training for clinical psychology, one can understand that it is often regarded as an accumulation of abstruse ideas unconnected to any aspect of reality. Reality comes from the student's maturing experience, on the one hand; on the other, reality can be identified in the problems posed by those who go to the clinical psychologist or the psychotherapist[5]. The psychologist sees, in the simplification deriving from the "emotive support" that the psychotherapist must guarantee the patient, a simplification to be hoped for, and that provides a solution. It is thought that affection, affective support, ready warmth, are "things" that anyone can guarantee: to provide all this there is no need for technical competence or a solid, articulate basic culture. It is sufficent to limit one's training to psychotherapy, to the search for a system of membership that can legitimize the psychotherapy profession. Think of the great number of psychologists "produced" in our country by a University which shows little interst in the students' demand, in their concentrating their professional expectations within the clinical degree courses, often superficial and confused, but legitimized by the subsequent enrolment in schools of specialization in psychotherapy. These schools often base their training on the presupposition that university education is useless, and that thanks to the fact of belonging to a school and studying a sectorial technique, it is possible to become psychotherapists. They would be psychotherapists trained in the most varied techniques, a-historical and a-contextual, with no connection to University training; but also with no connections with the problems that people, groups or organizations place before the psychotherapist. On this, it is important to consider the complex articulation of competence and culture required for a historically situated understanding of the problems posed to the psychotherapist. It can be understood, then, how affective support and empathy, are reassuring simplifications. These reassurances can soon be transformed into demands, within one's "forced" psychotherapy experience, preliminary to the profession. Freud dealt several times with the subject of the negative psychotherapy reaction. In his three-part conception of the mind, he sometimes attributed the cause to a force of the Super Ego, or to the masochistic need to remain in a situation of suffering. These are always intrapsychic explanations, and therefore a-historical and aimed at underlining the power of the death wish. I think a useful integration of the problems that the negative therapeutic reaction raises in many people's experience, but mainly in that of psychotherapists, comes from considering this matter in its relational and historical aspects. The

[5] On this see: Carli, Grasso, & Paniccia, 2007.

example of the psychologist-patient is illuminating on this point. It is illuminating because of the identification process that someone undergoing psychotherapy in order to practise the profession him/herself is led to feel towards the psychotherapist. If the identification stimulates growth, things can evolve in a useful direction for the psychotherapy relationship. If the encounter with the psychotherapist raises identity problems in the psychologist-patient, if it evokes envy and anger, if it provokes fantasies of inadequacy and social discrimination, if it highlights the fantasy of the insuperable gap between the two, then taking refuge in the unanalyzable demand can be a culturally comprehensible way out: a sort of proletarization of empathy, which upsets the scale of values. One who is seen as being culturally developed must necessarily recognise the limits of his/her affective involvement without worries, while one who is culturally in difficulty can claim an affective bond of which he/she feels capable. I think a dynamic of this type underlies many "false" psychotherapy experiences in the training of psychotherapists.

5 - Conclusions

This rapid survey of the issues involved in the report reflects the importance of this practice in the sphere of clinical psychology and psychotherapy training. This is the reason why from the beginning of the three-year degree course on Clinical Intervention, we ask students, as the final assignment for the basic degree, to draw up the report of their practical traineeship. This is the only direct experience students have of the psychology profession, in a context outside their training.
I believe that the report, as I have already said, is the second and indispensable phase of clinical experience, the phase which follows and organizes the lived experiences that the psychologist him/herself experiences within the relationship. I also believe that the area of the report has not yet been made precise and thorough in its methodology and its pragmatic value. For this reason the Review of Clinical Psychology/Rivista di Psicologia Clinica has devoted a specific section to this issue, in the hope that the area will arouse interest and participation, stimulate contributions from many and give meaning to a fundamental moment in the clinical practice of psychology.

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