The psychological relationship with mentally ill patients in the residential and semi-residential facilities of the Department of Mental Health. Traineeship experience.

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Abstract

The authors examine the role of psychology in the Mental Health Services, especially as concerns crisis intervention and rehabilitation. Practical traineeship experiences in residential and semi-residential facilities in Rome are discussed. A differentiation is made between "crisis" and "critical event". The former is seen as a breakdown in the pact of living together implicitly shared in a context and not seen necessarily as the fault of the single individual; the psychiatric crisis, in this sense, raises questions from the patients and their families to the Mental Health Services. The critical event is a psychosocial construct that places the crisis in the system of relationships and of involvements. Mental illness is therefore represented as the product and generator of critical events to be examined and explored so as to identify possible individual developments following the break, set in contexts.

Key words: Mental Health Services; crisis; critical event; practical traineeship.

Introduction

This paper aims to trigger thought about the role psychology can play in the Health Services that deal with mental illness, crisis intervention and rehabilitation. Our interest in these issues arose in a broader activity of reporting and thinking about the experience of the practical traineeship we are currently doing as students in different years of the Course of Specialization in Psychoanalytical Psychotherapy.[1]
An integral part of our training is the experience we have had as trainees in residential and semi-residential facilities, part of the network of services in the Rome area that deal with mental health problems. Specifically, these are a Psychiatric Service of Diagnosis and Care, two Therapeutic Communities, two Social-Rehabilitation Centers and a Day Center.

The specificity of the practical traineeship is due to its double nature: on the one hand a training experience and at the same time a service offered to the organizations where the trainee is working. In the perspective we are suggesting, the trainee role requires competence in developing and verifying categories of thought that are useful to make clinical interventions in contexts.
An element of complexity, but also a potential resource in being trainees, is the fact that one's presence in the health service is discontinuous and short term. Trainees are both participants in the activities of the facility and outside it; while retaining a degree of being extraneous to the health services, they share its internal representations and dynamics (Carli, 2009). This enables them to look at the organization from a different point of view of observation and reflection than that of those who work daily in the health services.
Belonging simultaneously to the training structure of the school, at the same time encourages them to use criteria for interpreting the relationship, enabling them to re-think the emotions experienced

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in relating to the context: it is thanks to the awareness of this double membership and to the work of finding criteria in the experience, that the learning process typical of the trainee can take place.

Through our experiences of practical traineeship we have identified, in the health service's capacity to manage crisis situations, a particularly important aspect of their operation. We discovered that it is not at all to be taken for granted that the same kind of situation represents a crisis that can be unambiguously defined as such in the various facilities. What is experienced and dealt with as a "crisis" depends instead on the relation between the individual and the organizational structure, with its aims, and on what is covered by the social pact linking the participants in the patient/Health Service relationship (Paniccia, Di Ninni, & Cavalieri, 2006; Carli, Paniccia, Di Ninni, Scala, Pagano, GIovagnoli, *et al*., 2008). In this article we will present three clinical situations in order to explore the ways the crisis develops in the different contexts, the elements that give rise to it, and how it is used in the relation between the clients and health services.
Starting from the clinical cases, we intend to offer a reading of the crisis as a break in the pact of living together implicitly shared in a context. We are therefore referring to an interpretation of the concept of crisis that is not to be attributed to and solved by single individuals, but is due instead to the breakdown of the systems of living together in society. If this failure generates a crisis, it can be said that it is the crisis in turn that generates the demands made to the health services by patients, by their families, by the broader context of living together. In this sense, we could redefine the health services that deal with mental health as contexts that take in crisis situations.
We will make a distinction between the concepts of *crisis* and *critical event,* in the hypothesis that they are anchored in two different models of interpreting the relationship between the user and the health services.
The word *crisis,* in the language of psychiatry refers to an altered emotional state, to the emergence in an individual of behaviors that differ from what is expected. To sanction the presence of the "crisis", there must always be someone who observes the other person's behavior, starting from the idea that actions can be explained in the categories of psychopathology and intrapsychic dynamics. We are in a diagnostic perspective, in which the crisis is attributed to the characteristics of the individual (Carli, Giovagnoli, Paniccia, Bucci, Dolcetti, De Berardinis, *et al.,* 2008; Bucci, Gibilisco, & Roselli, 2009; Brescia, Crisanti, Magrini, & Mazzeo, 2009).
By *critical event* we mean a psycho-social construct that involves the operation of establishing the crisis as an "event", with the aim of understanding what is happening in a system of relationships. To identify critical events one needs to keep in mind one's own direct involvement in the relationship with the patient, and hypothesize that what is happening has to do with this very relationship. We are thus moving into a perspective that places central importance on the relation between the patient and the health services, between the patient and the family, the apartment block, the neighborhood. We therefore propose a representation of mental illness as being produced by critical events and at the same time generating critical events. Our aim is to examine the events so as to identify the possibilities of development compared to the break-down point that the crisis causes in the context. We are interested in reflecting on the problems posed by working with mental illness and identifying the competences that may serve to organize a clinical psychology intervention in the various facilities.
Let us try to expand these issues by reporting some clinical experiences.

On the relationship between client and Day Center: making it on one's own

We are going to talk about Filippo, a forty-year-old man who lived in a therapeutic community for four years. In the past two years he had been part of a return to society program run by the Day Center of the Department of Mental Health. It is often suggested to patients that they attend the Day Center as an intermediate step between living in a Community and living independently, also to facilitate the organization of Apartment groups, small groups of users sharing a house and assisted by staff during the day.
In the period when he was attending the Day Center, Filippo started living with Enrico in an apartment on the outskirts, working as a masseur in the center of town and training a childrens' football team. During the session of the Day Center group therapy, Filippo expressed the desire to

come back to live in the city, renting a room thanks to his job and to the pension and the allowance form his Local Health Unit (ASL). The patient's desire was seen by the staff as being dangerous, hard to carry out and therefore to be discouraged. It was thought that by not encouraging his plan, they would be protecting Filippo.
As well as the changes in his life, in the same period, Filippo asked to be able to change his arrangements with the Day Center: specifically, he suggested changing the time of the weekly group, which he thought was incompatible with the time needed to reach his work. The staff however did not agree and did not think the time could be changed to make the session compatible with his work. They therefore felt that Filippo's *real* aim was to avoid participating in the session.
After this exchange of views, however, Filippo came to the Day Center less often and arbitrarily changed his medication, totally suspending the antipsychotic medication. After a short time his delirium became strong again, and his paranoia made living with Enrico difficult and had a bad effect on his performance at work. The patient also rejected an offer of help from the staff.
One night Filippo had an angry argument with Enrico and one of his guests, who Filippo accused of being Russian spies come to trap him. Enrico asked for the intervention of the relevant staff member who accepted the request and intervened to mediate in the situation. Filippo asked if he could stay the night in the therapeutic community to protect himself and others. During the night in the community Filippo said he needed further help and asked a staff-member to take him to the SPDC, saying that he needed "a place to feel protected, have time to think and get back into line".
Filippo's stay in hospital would last three weeks, during which he was visited by his staff-member, to whom he said he felt well, as if he was on holiday with time to think. During this time Filippo seemed to repair his connection with the Day Center, thanks also to the support of the staff-member assigned to his case. This result was also helped by the fact that the SPDC worked not only on containing the crisis, but also on the relationships between the patient and the contexts he was part of, acting as a space for thinking about the possible crises in these relationships.
On his release from the SPDC Filippo returned to participate in the therapeutic group at the Day Center and said that he had been through a hard time, when he needed to test his autonomy. "We users who start life again feel that maintaining the connection with you staff is like being tied to the state of being ill".
Filippo felt tied and dependent, and his experience of dependency had the emotional features of deficit, damage and illness; conversely, independence constituted the desirable objective that would seal his being cured. Being independent in this case meant not needing others, making it on his own. In the group therapy session Filippo also criticized the staff, underlining that they "exercize power without realizing it". On this point, he said: "you hold the strong power, you make us feel ill, you represent our illness and our past. To grow I have to prove I can do without you and medication. If you thought how you treat us, however, you could change the way you are with us!".
Filippo expressed the request for a mode of relating not based on asymmetry and the power of the healthy over the ill. The head of the Day Center, who participated in the session, suggested that Filippo think of the staff-outgoing user relationship like that between fathers and teenage children, when it is more difficult to regulate the distance to allow the children autonomy and development.

Our hypotheses on what has emerged so far.

His relationship with the Day Center aroused in Filippo the experience of depending on the facility, represented as the center of power that prescribes, decides who is inside and who outside of the psychiatric circuits, who is ill, who is healthy and who is cured. Filippo talked about the relationship with the facility as if there were no alternatives apart from depending on authority or opposing it and excluding for purposes of individuation.
The patient could be said to be rebelling, but it is useful to ask: which offer of dependency on the health service was his rebellion addressed to? What springs to mind is the relationship between the physician, with his strong technical power, and the patient. The same asymmetry of power was present in the Day Center head's hypothesis about the dependence between a father and teenage son, between the adult and the child, between those who know and those who do not know yet everything. They are situations in which individuals and their relationships seem to be taken for granted as known, in a position of high/low, strong power/weak power. Although the head's proposed interpretation tried to give a sense to the crisis as a crisis in the relationship rather than

of the individual, in which the relational offer that triggered Filippo's crisis was critically re-thought, it still seemed to attribute this crisis to the relational model being rebelled against, which saw him as needing treatment.
If we think of Filippo's two actions, we can distinguish two different modalities: suspending the medication and not attending the Day Center are choices based on a fantasy of autonomy in the sense of evading relationships, "being self-sufficient" expressed by Filippo to the staff in the therapeutic group. Other subsequent choices, like asking to spend the night in the Community and then being admitted to the SPDC, seem to be based on the fantasy of inverting the power relations the patient felt involved in, and using the health services exclusively for one's own needs.
The intervention of the Community and of the SPDC allowed for a reorganization of the demand acted out by Filippo: firstly the community managed to accept the request to protect the patient, then the admission to hospital favored the capacity to think about rather than to act out one's desires for bargaining.
To get a better understanding of what happened, let us take a step backwards.
Filippo's request to change the time of the weekly group session was considered unacceptable in practical terms, while it does not seem to have been explored in the group in its symbolic significance. It could be supposed for instance that the suggestion of changing the time was a way of negotiating with authority seen as being absolute and non-controllable.
We suppose that Filippo felt the need to conciliate and integrate within himself some very different relational positions: on the one hand in his working activity he had the chance to feel competent, on the other he continued to feel in a dependent position as a psychiatric patient.
Seeking space for bargaining can be seen as an attempt to integrate such different positions. At this level we do not ask whether the user's proposal should be accepted or rejected, but rather we try to understand the sense behind a specific moment in the therapeutic pathway. Similarly, the rejection of medication can be interpreted as a rejection of the relationship that forms the framework of drug administration, and therefore a rejection of the typically prescriptive mode that encourages feelings of dependency.
The decision not to take part in the group therapy sessions could also be seen not as a rejection of the sessions, but of the mode of relating that underlies the sessions.
In his own way, Filippo was inviting the facility to accept the relationship with him and to examine the work done together, thus verifying the progress of the therapeutic process.

In this perspective the hypothesis made by the head, linking the patient-Service relationship to the model of family relationships, can be interpreted as the expression of the symbolization shared in the health services: an emotional symbolization that conveys both the representation of the patient as a minor (as in the adult/child relationship) and that of the person in development, endowed with resources that can emerge thanks also to the work done by the health services.

On the relationship between client and Social rehabilitation community: rebelling against the rules

We will now present another case in which the critical event construct can be used to understand the sense of the psychotic crisis manifested by a patient, Ilaria.

Ilaria is 35 years old and had been in a rehabilitation community for a year and a half. The shared image in the community was of a person who is generally quiet and calm, and who related almost exclusively with the staff-member assigned to her case. Recently the staff had had the impression that Ilaria was more irritable, especially on Mondays.
Often in the health services the calm attitude of patients is seen as proof that everything is going well, with no particular problems to deal with. The image of the calm patient is also linked to expectations of passive dependence as the hoped for mode of relating. The opposite extreme in the continuum of desirability, therefore, is the irritable, agitated patient, who for instance contests the rules, refuses medication, and asks for explanations.
To return to Ilaria, the critical event we are going to report is related to the request made by the patient to one of us trainees in the Community one Monday afternoon. That day the trainee had

been appointed for the first time by the staff to be the referent for the facility, that is, the person the users can contact if the staff are busy with other clinical activities.
During the session between the staff and the group of patients, of which she was part, Ilaria left the group, looked for the trainee and demanded the return of her mobile phone. We must say first of all that the patient had a precise agreement with the community, whereby she was allowed to use her mobile only at certain times. The purpose of this rule was to prevent Ilaria from using the mobile whenever she liked, in order to control her compulsive calls to her family doctor. Before being accepted into the community the patient had even been accused of stalking due to her behavior.
The trainee used the anchorage to the rules to answer Ilaria, refusing to give her the phone. Ilaria, in a more and more urgent tone, said she needed the cell phone for a specific reason: to call her parents to get them to come and pick her up and leave the Community.

Faced with the trainee's firmness about the rules and the need to speak to her staff member about using the mobile outside the agreed times, the patient got increasingly angry. In rapid succession Ilaria locked herself in her room to pack her bags, shouted in desperation, threatened to make a scene if she didn't get her phone and started to pick and punch the door of the room where the telephone was. Her staff-member intervened and tried to make her have a calm conversation, alternating with trying to physically restrain her, but Ilaria ran into the refectory where, more and more desperately, she overturned tables and threw benches around. The staff-member managed to calm her down and bring her back into the group which she had abruptly left, insisting that she wanted to talk to somebody about what was happening.

In the following days Ilaria sneaked drugs and alcohol and tried several times, and managed, to get hold of a phone. On one of these occasions she came to blows with her staff-member. The community offered various opportunities to talk about her decision to leave the program and to return home to re-think her therapeutic contract and her motivations.
After a month, Ilaria returned to the community and on a Monday in a long interview with a trainee told how she had experienced being in the community in the last part of her stay. She told about her experience of discrimination from other residents and some staff-members who were allowed not to follow the rules that should be valid for everybody; she talked at length mainly about food consumption and the chance of speaking in the group. On this point she talked about what happened on the Monday that she left the group, angry about the unfairness suffered, since for the umpteenth time another resident had been allowed to break the rule that in the group each person could speak only once, a possibility which had been denied her.
She felt that there could be exceptions to the rule, but that this did not apply to her; that the person in charge of the group and her staff-member used their power to exclude her from certain privileges. She then stated that in the last few months she had felt a very different part of herself emerging, less obedient, inhibited, unlike the calm and accommodating Ilaria of the first months in the community. She said she felt like opposing and contesting and that this created problems in the community, worsening the unfairness towards her by the staff, who she didn't trust any more. All this led to the patient saying: "being here in the community is no use to me, I'm not improving. I prefer to go home". The following Wednesday Ilaria would leave the community again.

From our perspective as trainees, what hypotheses can we make on this case?
We proposed it as a case that tells about a crisis, but whose? The hypothesis we make is that the rules can work as a framework within which to understand the patients' movements. What does it mean if a patient enters into conflict with the rules of the community? Or stops feeling passively dependent on the staff? The risk is that it is considered a worsening of the patient's illness, reducing an event involving the relation with the rehabilitation facility to a psychopathological phenomenon.
We suggest taking another road, and hypothezising that the patient, engaged in the attempt to integrate parts of herself, was feeling ambivalence in experiencing the relationship with the facility. Moving from a relationship of passive dependency to a phase of conflictuality, cannot be taken for granted as a signal of the patient's improvement or worsening. It is, instead, a "demand" to analyze and in this sense it is useful to ask how the community can take responsibility for such aspects.

Perhaps life in the community aroused in Ilaria some experiences of competitivity towards having to share, and agree with others on the right to speak. Ilaria clearly said she was jealous and angry with the head and her staff-member, she offered the fantasy that the others got privileges and she was discriminated against. If we make a symbolic reading of the dynamics of envy that Ilaria presented, we can see that the complaint was a pretext, a way to talk about her feeling of exclusion, of how she experienced what happened in a persecutionary way. We think that Ilaria's fantasy of omnipotent greed, which wanted to possess everything, did not allow her to tolerate facing reality, because reality places limits on a fantasy that is total. She wanted to possess her staff-member, so that she was not available to other patients; she wanted to speak in the group without negotiating.
The experience of exclusion is prompted by not being able to own all that one wants. Ilaria's greed was connected to the way the Community presented itself in relation to its guests, as a source of nutrition: on the one hand the community offered to be food, on the other the patient's voracious need to have it all for herself. Ilaria seemed to be increasingly affectively hungry the more the community perceived itself as a source of nutrition for her.
If we keep in mind Ilaria's fantasies concerning the community, we can understand that the rules become a frustrating aspect to tolerate. Through the rule, the community can regulate its being a source of nutrition, the presence and absence of the good object.
We could hypothesize that Ilaria asked the community to satisfy her voracious desire for affection, and to let her feel privileged compared to the others. However there was no food that could fulfil the patient's request. Ilaria's refusal to stay in the community therefore seems to take on the meaning of a failure of the fantasy shared by Ilaria and the health services to be satisfied and to be able to satisfy.

Ilaria's case enables us to reflect on the role of the rules in living together in a therapeutic community. Often in these communities the crises are related to violation of the rules.
In our experiences of practical traineeship in a community we have learnt that the rules can be useful tools in organizing the life together, and that they can acquire sense in relation to the aims of the intervention. We wish to underline that the rules are tools that serve especially when they are designed for the creation of a product, bringing into play the desire of each person and at the same time the need to keep agreements in order to get it done. Let us give an example by describing what happens in one of the rehabilitation communities where we work: in this case the patients agree with a staff-member to save part to the money they receive daily, to spend on an evening in a pizza parlor. The rule is then closely connected to a third element that gives it sense, and that places the patients in an experience of planning. In other cases the rules simply serve to inhibit behaviors, following the logic of "rationing" typical of institutional contexts. We think this second type of rules may have different effects: in certain cases they serve to guarantee containment, while in others they have to do with the development of the competence of relating in systems of organized living together. This competence is what we see as the main rehabilitative aim of facilities for mental illness.

The situations reported so far highlight the fact that what in commonsensical terms is called clearly "crisis of a psychotic patient", from an alternative perspective can be thought of as a signal of a change in the relationship between patients and health services, and therefore a clue to the need to rethink and renegotiate the sense of these relationships. They also show that the psychological role in the health services concerns the possibility of constructing settings where individuals, perhaps starting from pretexts like the issue of the rules, can talk instead of acting out.
For example, when the trainee was faced with Ilaria's request, she almost exclusively acted on the containment of the insistent request – by sticking to the rule – and therefore lost the chance to relate to the symbolic aspect of the request and to talk about it with the patient.

The contrast between crisis and chronicity

As we said at the outset, the crisis takes different forms in different contexts.

In working in the SPDC we have understood that in a facility oriented to dealing with patients in crisis it becomes a problem to relate to patients defined as being chronic, and it is especially difficult to organize work in connection with other health services for a referral. It is interesting that the relationship between crisis and chronicity is inverted in the case of the Communities, which are often organized collusively on the chronicity of their clients, and may feel severely challenged by episodes of crisis.

Let us now examine the SPDC.
We have said that the SPDC seems to be able to function efficaciously in acute cases, while an experience of crisis and of inadequacy in the health services emerges in relation to the patients who are periodically admitted or decide to admit themselves, with a long history of relationships with the health services. Patients are admitted to the SPDC to contain acute crises, which, as we have already said, we hypothesize are relational crises with the context of living together, and possibly to agree with the patient on a plan or referral to other health services which will take responsibility. Chronic patients seems to severely challenge this type of intervention.

The last clinical situation we are going to describe shows that chronicity, just like crisis, can be re-read not as a condition of the individual, but of the relationship between users and the health services.
Adele was a 74-year-old widow living alone; she arrived in the SPDC after an intervention by police and psychiatry, who had been treating for her, after a complaint by neighbors disturbed by loud music. Admission was judged appropriate, due to Adele's condition, that is, in "the grip of delirium". The trainee, consulting the clinical record, learned that Adele had a long history of admissions and a diagnosis of schizotypal personality disorder. According to the health services staff, Adele could not go home because she was not able to look after herself.
It was hoped to send her to an Assisted Health Residence (RSA), but the long waiting lists delayed her release from the SPDC, although there was no sense in her staying on in the division. Adele's stay lasted several months and this was explained by the impossibility of finding a context that could take care of her. While waiting for a place in the RSA, Adele continued to be stabilized with medication, but after a short while she started to say she wanted to go home and not to go into another facility. The staff said "this is the best she will get", meaning that the therapy with Adele did not seem to be leading anywhere, with no possibility of evolution, also in view of her long history with the services.
It is interesting to look closely at how in this period Adele made a development in her fantasies on the health services: at first, SPDC was seen as a friendly system that she could trust; later the health services started to take on persecutionary features in her delirium about guards, police and prisons. In this phase, Adele started to swear at the staff saying that it was illegal to hold people and violate their freedom. Adele's fantasies and delirium were about the relation between herself and the facility she was in. The fantasy of being a prisoner suggests the difficulty of making sense of the admission without an aim and without a plan.
We think Adele felt her life expectations were being rejected by the health services and this was reflected in her refusal to go into the RSA, since it was the reification of the idea that the health services were forming of the relation with her: namely that there was nothing more that could be done for her. The patient's critical response to the proposal to enter the RSA, rather than further evidence of Adele's inability to look after herself, seems to us an attempt to express, by acting them out in her refusal and also in her delirium, the emotions she felt in relation to a health service that had difficulty constructing with her a path for her return to society, and that resorted to sending her to a place seen as "detention", in a similar light to the hospital stay she was experiencing.

This case seems to show the contrast between crisis and chronicity in the network of health services, and the possibility for these two aspects to be examined differently according to the mandate of the specific facility where the intervention takes place, in order to understand the relationship with the patients and the possible developments of these relations.
Adele's chronic state, the impossibility of referral, in this case severely challenge the therapeutic aim, diagnosis and treatment of the SPDC, before being the patient's problem.

Before being a characteristic of Adele, chronicity can be seen as typical of the relationship between her and the health services, as well as between Adele and her contexts. 'Chronic' seems to apply to a relationship to which the same emotional symbolization is always given, regardless of the product, and of the contextual dimension which can give it new meanings.
The SPDC's representation of its intervention seems to be tied to the urgency of admitting the patient and the shortness of the hospital stay. In contrast, the intervention in the Community is offered in a watered down form over such a long period that at times there is the experience of absence, of the annulment of time and planning. This internal representation of the mandate present in two different contexts of care is counterbalanced by the demand presented to the health services by the patient's context of relations: for the SPDC it seems to be "accept them immediately" and for the community "keep them in treatment as long as possible". This clearly shows the profound diversity of the health service aims, and the relationships they have with other health facilities in the network, despite their having an institutional mandate in common.

Conclusions

In this paper we have tried to reflect on what it means to work with mental illness and face crisis situations in these facilities. We have presented three reports on a crisis in the relations between clients and facility they are involved with.
We are thinking of Filippo asking the Day Center to support him in his attempt to integrate different, changing parts of himself: the more autonomous, competent parts experienced at work, and the parts that need therapeutic support. We are thinking of Ilaria asking the social rehabilitation community to satisfy all her affective needs; and then we are thinking of Adele asking the SPDC to integrate her life expectations into her therapeutic plan.
The health services approach the crisis starting from specific hypotheses about mental illness and about the patients' needs. In the first case, the health services regard Filippo mainly as in need of treatment, in the second case the community presents itself as the one that can sooth wounds, volunteering to fill the affective vacuum felt by Ilaria. In the third case, the SPDC experiences a sense of impotence in the relationship with Adele and offers her RSA, which however looks like a stopgap measure, due to the impossibility of seeing prospects of development.
Mental illness therefore seems to be identified at times with the need for treatment, then with the need for affection, and then again with the impossibility of finding a prospect of improvement, representations and proposals of dependency on the health services against which, moreover, the patients rebel. What we do want to underline at this point is the risk of such representations being clearly acted out in relation to the patients. By contrast, we want to suggest that it is important to think of mental illness not as something stereotyped and static but as something that acquires a sense, changes and evolves in the relationships concerning it.
The demand presented to the health services is to deal with relationships, to develop criteria for interpreting relationships that make it possible to intervene therapeutically on them, instead of on the single individuals. We have seen for instance, that in the representation of the health services, a crisis often coincides with a rejection: Filippos' refusal of medication, Ilaria's refusal to stay in the community, Adele's refusal of the referral by the SPDC. We therefore hypothesize that these refusals acquire sense in relation to the specific mode of relating established in these contexts, and to the dependency offered to the users by the health services.

To conclude, let us return to the psycho-social construct of critical event as an event that severely challenges the implicit assumptions in the operation of the facilities, and that can therefore make the health services re-think the relationships it establishes. We offer this construct as the criterion that enables problems arising in the facilities to be treated by linking them to the specific aims pursued by the facilities themselves.
A patient's acting out or acute crisis, a staff-member's experience of impotence or failure, can draw attention to the facility-user relationship, prompt a verification of the work done and re-orient it to the aims of the facility.

We feel that the practical traineeship in the contexts of mental illness can concern the emergence of critical events starting from the crisis, in order to reflect on the relations that are established between users, between users and staff, between the facility and the local area.
As far as this is concerned, we think the fact that the trainees are in an intermediate organizational position enables them to act as a resource for the understanding of such relational dynamics. The possibility of talking to users and staff about the relationships experienced in the facilities and the emotions associated with them, as well as the facilitation of relating, may be areas of intervention in which the practical traineeship can become a factor of development for the health services.

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