Psychiatrically ill individuals and the demand for psychotherapy in the Mental Health Services
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Abstract

This was the introductory talk at the Conference held in July 2010 "The clients of the Mental Health Services" sponsored by the School of Specialisation in Psychoanalytical Psychotherapy run by *Studio di Psicosociologia*, Rome. An analysis is made of the Mental Health Services and the possible relational dynamics in the health services and in the facilities where the trainees carry out the practical traineeships for their specialisation. Establishing a relation between the staff and so-called psychiatrically ill patients entails a series of problems. Some of these are dealt with here, based on the reporting of practical traineeship experiences. The staff-member, in these cases, is seen as a thinking support for the emotions of the mentally ill individual, an integrative role that can give a sense to the patient's emotions and translate them into a coherent and communicable continuum. Another aspect dealt with is the evolution of the relationship, inside the services, between demand and supply in Mental Health Centers which, especially since the Nineties, has not been connected only to mental illness. In recent years the psychotherapeutic service has been accompanied by pharmacological intervention and rehabilitation initiatives for the return to society. This paper examines the phenomenon in depth and suggests categories and critera of interpretation and intervention.

Key words: Mental Health Services; psychiatric patient; pharmacological intervention; psychological intervention; practical traineeship.

Introduction

In this second conference on the practical traineeship of the SPS School it has been decided to look at the Mental Health Services and the different relational dynamics possible inside them. We know that the practical traineeship is not limited to this type of health service: valuable experience of practical traineeship has been gained from investigating psycho-social risk factors at the San Filippo Neri hospital and from working with patients and family-members in the Sacro Cuore Hospice, a center for palliative care in Rome.
The practical traineeship brings our students into contact with different facilities in the area of mental health. The aim of this seminar is to differentiate the facilities according to criteria that help the students in their traineeship. A criterion that is fundamental for us concerns the mode of relating, in view of the contexts in which the traineeship takes place. We therefore want to steer the school's clinical psychology thinking towards the relationship and its characteristics, imposed by the type of work and at the same time at the service of the aim that is sought through relating.

Psychiatric patients

In the Mental Health Services there are different operative facilities (CSM, SPDC, Day Hospital, therapeutic and rehabilitation communities and half-way houses) and different professions (psychiatrists, psychologists, nurses, educators, social workers, technicians of psychiatric rehabilitation).

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The complexity of these services, on the other hand, seems to be designed for and accessible only to psychiatric patients; namely "serious" patients who, as the 180 says, present such psychic alterations that an intervention of psychiatric therapy is required. These forms, to be very brief, fall into the area of schizophrenia, paranoia, depression or psychopathology.
As we will soon see more specifically, they are psychopathological forms where it is difficult if not impossible to establish a dual relationship designed to develop thinking about the fantasies that are aroused by relating to reality; in particular by the reality of the relationship with the care facility and with the psychiatrist, the psychologist, the nurse or educator who interact with the patient. In other words, they are psychiatric forms where the symbolic dynamics are acted out rather than being thought. In these psychiatric forms the favored intervention is psychopharmacological, designed to reduce the distress caused by acting out fantasies; at the same time, it is important to make an intervention that can facilitate relations with the context. Illness can in fact be manifested and express itself in symptomatological forms that are not "tamed" enough by the specific effect of psycho-pharmaceuticals; such behavioral symptoms can make it so hard to relate to the context of care that restraining interventions may occur, unless they are elaborated through relations with the staff. The main aim of the psychopharmacological intervention, in sum, is to make the return into society of these patients more acceptable. Such a return is also affected by the construction of networks supporting and facilitating relations, with the purpose of enabling living together to be acceptable both in the family and in the SPDC, the Day Center, and in therapeutic and rehabilitation communities. The problems of these patients in most cases do not allow real psychotherapeutic relations, in the sense usually given to this term to indicate the establishment of thinking about the emotions brought to the psychotherapeutic relationship which is structured according to a specific setting.

It is therefore important to underline that with psychiatric patients, the psychological and psychiatric aim is to establish a relationship with the patient, which makes him feel less isolated and alone, and which allows him to communicate in the ways made possible by his typical mental situation. Such a relationship may be full of surprises and emotions, it may be moving in the depth of the emotional understanding and in the intensity of what is communicated, in the attention to the questions involved and their understanding. This relationship, we should underline, is possible within specific structures that contain the patient: the Psychiatric Service of Diagnosis and Care, the Therapeutic and Rehabilitation Community and the Day Center. At the same time, it is only in the very long term and only in specific individual situations that this relationship can result in an "improvement" in the patient and in his real return to autonomous working and affective experiences. It needs to be stressed that the aim of returning to society in the case of psychiatric illness is mainly designed to facilitate and make it possible for these patients to live in the family; living in the family as an alternative to admission to a lunatic asylum[1], which marked the experience of patients in the past. Finding a place in the family, or in relational facilities that replace the family for those who cannot rely on a family capable of welcoming and caring for the patient: communities, half-way houses, sheltered accommodation.
Those starting psychological work with these patients, as we have said, have the aim of establishing relations with the patient. What does "establishing relations" mean? We feel that there are two issues in this praxis: one is related to the stereotypes that the staff-member may have towards the mentally ill individual, the other concerns the relational peculiarities of the patient himself.
For example: a young psychologist, enrolled in the first year of a school of specialisation in psychotherapy, is doing her practical traineeship at the Day Center of a Mental Health Center, DSM. She has agreed on times and ways to be present with the head of the service, and goes to the Day Hospital for her first day of work. She arrives and the receptionist tells her the Head is in a meeting. The young woman is invited to wait in the center's common room. Here, for the first time in her life, she meets mentally ill people. In her report on the event, she says the patients showed

[1] In Italian, "manicomio", from the Greek *mania* meaning to be furious and mad, and *komion* meaning hospital. It is interesting to consider the negative connotation, indicating an uncontrollable confusion, as used in everyday Italian: "*questa situazione è un vero* manicomio!"

their “mental illness” in a far clearer way than she had expected: one man is curled up on a divan and looks tiny, almost like a cat. A young man is staring at the corner in front of him, with no visible facial expression. The young woman ventures into the rooms adjoining the common room, when she suddenly hears voices indicating that the meeting involving the Head she has come to talk to is over. She looks for the common room, feeling embarrassed because she feels lost. She finally gets back to where she started from, but can’t see the Head. She murmurs to herself, “I’ve missed the doctor!. Near her there is an old lady with her mouth open and a vacant gaze; the psychologist perceives the absence of this woman, when she spoke half aloud, never thinking that the woman was paying attention. But in a deep voice the woman says to her: “the doctor has gone to the bathroom and will be back soon”. The resulting amazement of the young psychologist, forced to revise her belief about the “presence” of the woman, her timeliness in grasping her concern about seeing the doctor, and the offer to relate that her utterance expressed. Another example: in a therapeutic community, a young psychotic who is a long-term resident in the community, has not been able to sleep for a couple of nights and has been walking nervously around the rooms in the facility smoking and often talking aloud in an agitated tone, disturbing the sleep of the others sharing the place. The nurse on night duty comes up to him and asks if he is afraid of being alone; at the same time she moves his mattress next to her own bed. The patient curls up under the covers and sleeps peacefully until morning, “like a little child”.
These are two examples of possible relations with a psychiatric patient. Such a relation leads to overcoming the distancing stereotype that stigmatises the mentally ill person in the first example; and in the second case, shows competence in grasping the emotions communicated in the problem behavior of the young man agitated during the night.
In our view, what characterises the “seriously” mentally ill person is the lack of thinking about the past experiences evoked by the events typical of his experience in the various contexts. Every past experience evoked by different aspects of reality, is transformed into acting out which in its expression, exhausts and impoverishes the emotional response to the event itself. In this the mentally ill person differs form the one who presents a problem, which can be defined as thinking about the past experience symbolic of an event in reality, and which can therefore be treated with psychotherapy in the Services offering this treatment. We will come back to this later.
Let us get back to the role that can be assigned to the relation that is possible between a staff-member and a psychiatric patient, in facilities for the containment of mental illness. In these facilities the mentally ill person finds himself facing three kinds of relations: *the relation with the rules* governing living together, *the relation with the group of residents* and *the relation with the staff*.

The rules

Let us have a look at the rules typical of almost all facilities for the containment of mental illness. At first sight, there are two kinds of rules: some rules concern the regulation of living together with other residents: don’t smoke in the common rooms, in the canteen or the bedroom; keep the shared spaces tidy, save some money so that there can be a specific shared activity (all going out for a pizza for instance); let people know when you will be late coming back from an outing with the family. Then there are some rules that, though addressed to all the residents, are stated in such a way that each person perceives them as a personal constraint: for instance, don’t have more than two coffees a day, smoke no more than one cigarette every three hours, keep your locker tidy. It is interesting to notice that the rules about living together are in general accepted more than those that are felt to be limitations on one’s own freedom of initiative. It is also interesting to notice that an important rehabilitative aspect pursued in these facilities is based on getting mentally ill people to accept rules.
Let us look briefly at the dynamic implicit in setting rules and demanding their acceptance. There are rules that, as we have just said, act as regulators of living together: they are called “rules of the game”. A rule of the game is not anchored to a principle of authority, but to the necessary limitation of individual initiative, so as to make living together possible: obey the traffic light, wait your turn in the queue, respect the property of others. They are rules that have the implicit meaning of the respect for reciprocity. Pushing into a queue, for instance at the post office or at an exhibition,

means establishing the failure to respect reciprocity; just like not taking property into account, or going through a red light: if the principle of reciprocity is not upheld in following the rules of the game, an uncontrollable, anarchic situation is established, where each person, thinking that the failure to follow the common rules forces one to pursue and defend one's own interests, makes regulated living together impossible. In this case, living together is modelled on the "homo homini lupus" mode, in a fight to the death, of "one against all".
In the case of the rules of the game, the "authority that makes sure the rules are obeyed" is represented by the person delegated to this task and acknowledged by the group living together, with the sole aim of making it possible to live together. An example could be the traffic policeman at the traffic lights on intersections, or the custodians who regulate the queue for entry into an important art gallery.
On the other hand, there are rules that are imposed by an authority principle. A competent authority, such as the physician who puts a diabetic or heart patient on a special diet, or prescribes a specific medication for a patient with hypertension. In other cases it may be an authority whose legitimation is based on setting the rules and enforcing them, which serves only to sanction the difference between those who set the rules and those who are subject to them; the difference between the one who "knows" what is good for the other person, and in the name of this knowledge, imposes ways of living or rules on the other person. This is based on the authority deriving from acting for the good of the other person, even if it is against his will. This applies to rules made by parents for their children, "for their own good"; it applies to rules that, as in the case of the maximum number of cups of coffee that a mentally ill patient can drink per day, are based on a "health" pretext, which is actually a limitation placed on a desire. Such a desire may, in turn, be increased by the simple fact of being limited. Therefore rules are for living together, or based on an authority principle. The latter are much more difficult to impose on a mentally ill person; at the same time, they are also the ones that provoke more transgressions and conflicts in a social group. When in a system of containment of mental illness rules are set based on the authority principle, it is easy for the conflictual dynamic to be triggered and to become serious. A conflict is set up between understanding and a-critical acceptance of the authority principle. The latter, if accepted, often evokes regressive, infantilising processes; if it is not accepted, it entails aggressive confrontations and demands for explanations of the rules imposed. This type of rule can, in some unfortunate cases, increase the sadistic component in those embodying the authority principle that is imposing the rules.
Let us think of a therapeutic community where the patients, though having workshop activities and some tasks to carry out, find themselves severely restricted in the expression of their affectivity: they have no sex life; they have no real paid working life; they cannot do anything to satisfy their aspirations to learn, to gain new competences; they have no chance of deciding about their free time, their social relations, leisure or the development of personal interests. Life in the community is as poor as the perceived affective life of these patients. Often the consumption of coffee and cigarettes is for most patients the only area of satisfaction of desires. Such desire can be expressed in an exaggerated way, if it can be fulfilled without any rules; it is a desire that can become transgressive, if restrictions are imposed in this area. The patients often don't understand restrictions, which are symbolised as unquestionable expressions of the medical or administrative authorities of the community. It is in these experiences that the relation between staff and patients can act as important emotional and symbolic contents. The staff-member, in fact, can take on the role of mediator between the desire and the rule; between the motivation to break the rule and the mortification involved in a-critical acceptance of the rule. The fact of relating enables communication to start "about" the rules, it allows a sense to be given to the rules and initiatives to be implemented of a "negotiated" kind, designed to improve the limits imposed and to promote some concessions. Relating, in other words, allows for the transformation of the imposition of rules into a conflict between those setting the rules and those subjected to them; promoting conflict allows thinking to be done about the emotions aroused by the rules, and therefore participation in the negotiation on which living together is based.

Relations between patients

Relations between patients add a further element of complexity to the social systems that act as containers of mental illness. This kind of relation is the place where the symbolic relational fantasy of mentally ill patients is expressed. This means that relations between patients in an SPDC or in a therapeutic or rehabilitation community requires constant work of symbolic translation, designed to make sense of the relations themselves. Often, this translation of sense has the power to reveal a vocabulary that is in contrast to the rules. Relations between patients also allow the individual personalities to be highlighted, as well as the way they are manifested in the group of fellow residents, and the image, perhaps stereotyped, that each one assumes for the others in the group. These are always acted out relations, where the symbolic dynamic is translated into actions in the group of patients. Think for instance of the young woman who "caused" her own admission to the SPDC, using the aggressive drunken state she periodically reached in her rehabilitation community: as soon as the drunkenness is over, the patient is ashamed in front of the SPDC staff for her previous state and brings into play a collaborative attitude that after a few days in the SPDC, leads to her helping to do small jobs, make beds or cook. As soon as she goes back to the community she starts drinking heavily again, which makes her adopt aggressive violent behavior with the other residents in care. And the cycle of admissions to the Psychiatric Service starts all over again. This patient seems to accept the system of containment and care in the SPDC and at the same time seems to reject the relative independence and responsibility of the community, from which she escapes through drunkenness. Without work on restitution by the staff towards the symbolic dynamics that are acted out in the relationship between patients, the risk is that the relations themselves in their repetitive, stereotypal component, may "fix" the patients' roles and self images, in reductive features of their social acting out. To this end, it would certainly be useful to have a working group for discussion of life in the community. However also the daily participation in the ordinary routine life of the community or division is needed; the possibility of intervening in social interactions amongst patients or between patients and staff. We remember a trainee on his first day at work in a therapeutic community and the fear he felt in exchanging even a glance with a patient who stared at him for several minutes with an expression of the greatest hatred. It was only after a few days that the trainee asked the patient the reason for his hostile behavior. The patient answered that it was just a precaution designed to protect himself from possible hostility from strangers. It was the same style he had been using since he entered the community and that had led him to be isolated, rejected by the other patients who scarcely tolerated his defensive measures. The trainee managed to talk about it with the patient, together with other residents; after a few days the patient's behavior was clarified and his isolation was considerably reduced.

The relationship with the staff

An example: in a rehabilitation Community, a patient left the community to go and visit an aunt who lived a few kilometers away. For some of the community staff, this patient's behavior was immediately translated as an "escape" from the community and sanctioned with the patient being picked up at the aunt's house; he was brought back "under escort" to the community, with a subdued return that clearly smacked of defeat. In the group of patients in the community there then began a discussion about the "fugitive" patient's behavior: many agreed that it was not an "escape"; the patient had not run away, but had gone to see his aunt. Just as a family member who goes to visit a relative is not "running away" from the family. The escape concerns a transgressive interpretation of the event; going to see his aunt responds to an interpretation of the emotions and desires acted out. Often in the relationship between patients and staff, one of the main difficulties is to reconcile rules and desires.

A south American patient sees a progressive deterioration in his behavior in the few years of contact with a mental health service; he had arrived at the service due to problems of inability to look after himself: he had recently lost his job, and therefore also the house and relationships with the few friends he had been able to make. He did not know where to sleep and what to eat. The health service intervened, but the young man gave in to the temptation of alcohol and his state deteriorated more and more; he ended up living with the tramps sitting on the grass in front of the building where a charity group works, drunk all day long, committing petty thefts or begging insistently, to be able to buy wine to deaden his mind. The reason for this deterioration is not clear.

One staff-member, on the other hand, recalls hearing that the patient has a family in a south American country, who expect great things of the son who had come to seek his fortune in Italy. The fact that he disappointed this system of expectations may have contributed to accentuating the destructiveness that the patient acts out towards himself, as if to get away from the humiliation of a failure. The job he lost, moreover, was as a cleaner in a large company, so it was a low level job with no hope of advancement in a career and no chance of success. It would be interesting for the staff dealing with this case to investigate the patient's experience of the expectations of his family, from which he seemed to move away emotionally through his mind-deadening destructiveness.
The relation between patients and staff differs from the relation between the patients and the rules: with the staff there is always the hope of finding understanding and indulgence, friendship and the capacity to control one's emotions. That is why it is important for the staff to be able to emotionally grasp and transform into thought, the emotions that the patients cannot understand, do not know how to symbolise and even more, cannot even think about. The staff-member can be seen in these cases as a thinking support for the emotions of the mentally ill person; an integrative role that is able to understand and make sense of the senseless emotions of the patient, can translate them into a coherent and communicable continuum. The relation between the staff-member and the group of patients, for instance in a community or in an SPDC, can play the same role of translating what is experienced and acted out in the group, so that the group can recognise the meaning of the interactions that are acted out within it.

The demand for psychotherapy

We have talked about the the that it is not yet clear why, along with taking care of psychiatric patients, the Mental Health Services agreed to the increasing common and numerous demand for psychotherapy. Some CSMs, for instance, exclude psychotherapy from their activities, to devote their resources entirely to the placement and upkeep of mentally ill individuals, so as to prevent them from becoming chronic. Such chronicization would entail a worsening of the patient's capacities for living together and his institutionalisation in facilities which closely resemble the old Psychiatric Hospitals. This however does not apply to the majority of Italian CSMs. This means that the majority of CSMs deal with pharmacological care and facilitation of the mentally ill patients' placement in a social context, but at the same time carry out extensive psychotherapy activity. It is interesting to notice that the former activity involves psychiatrists, psychologists, educators, psychiatric rehabilitators and social workers; in the second activity, instead, the only ones involved are psychiatrists and psychologists. Nurses in some CSMs, carry out secretarial duties to cope with the demand for psychotherapy.

How did this demand arise?
It is hard to give a general clear answer to this "phenomenon", strangely not envisaged in the law 180 and seemingly in contradiction with the aims of the movement of localised psychiatry, designed for the closure of the psychiatric hospitals and the placement of serious mentally ill patients. This placement in the family or in institutions designed for the purpose, at first required intense and widespread work in the local area where psychiatric patients were placed in order to avoid crises that would have called for a compulsory admission (TSO). This would have interrupted the process of recuperating ties between the patient and the family and at the same time created disillusionment and fear about the feasibility of the placement itself. Every psychiatric crisis, every time the TSO was resorted to, was considered, in the period immediately after the introduction of the 180, a failure of the psychiatric work that set out to prove the clear possibility of placing seriously mentally ill individuals in family care. This is why the first CSMs worked assiduously and extensively in their local areas, using above all nurses, alongside social workers, psychologists (often assimilated to nurses in the role of single staff-member) and psychiatrists, for the prevention of psychiatric crises in patients placed in family care or in local facilities.
This intense work in the local area gradually lessened, accompanied by the revelation of the enormous difficulties encountered in carrying out the family placement of serious patients. Their gradual shift into therapeutic communities or institutions replacing the family (sheltered apartments, half-way houses, etc.) has increasingly restricted the activity of the CSM to inside the walls of its

facility. In parallel with this withdrawal into the institutional premises of the CSM, was the pursuit of a progressive specialistic training in psychotherapy, both by the psychiatrists and by the psychologists working in the Mental Health Services. To this was added the habit, on the part of many people with experience of some emotional, behavioral or relational difficulty, of asking the Mental Health Centers for help and advice. This process was then completed by word of mouth, increasing the demand for psychotherapy to its current high levels. As we said earlier, a person making a demand to the CSM does not actually ask for psychotherapy but presents a problem to the service. This is an extremely important difference. In fact it is the distinction that can help to understand the profound difference between the demand for a specific psychotherapy (psychoanalysis, systemic or cognitivist therapy) in the private area and the demand that *poses problems*, in the area of the public health service.

As we have shown many times, the demand related to a specific psychotherapy usually requires only the analysis of feasibility of the therapy itself. This analysis, for instance in psychoanalysis, involves the applicability of the analytical setting: in sum, the capacity to "free associate" during the session on the couch, strict adherence to times and the ability to pay for the therapy. In other words, competence to work psychoanalytically, developing thought on the emotions aroused by the analysis situation and specifically by the relationship with the analyst, expressing the emotional thought in words and interacting with the analyst's interpretations. It is important to consider that psychoanalytical therapy needs no diagnosis of the patient's disorders and no preliminary analysis of the problems presented, but only the feasibility study of the treatment. Consideration of the disorders and problems posed by the patient usually occurs in the analytical relationship.
Quite different is the situation faced by the CSM staff-member who receives the demand of a person coming to the health service.
Let's see the components of this difference.
The psychiatrist or the psychologist doing psychotherapy in the CSM is firstly faced with the motivation of the person coming to the health service: a motivation dictated by a problem, not by the desire or intention to undergo psychoanalytical therapy, be it of the couple or otherwise. As we have said, the problem can be defined as a symbolisation, emotionally anguishing, painful or worrying, of specific events that the person encounters in his existential reality. Before the presentation of a "problem", the staff-member preparing to carry out psychotherapy has two possible paths to choose: diagnosis or analysis of the demand. These two paths are hard to reconcile. Diagnosis (Carli, 2008), in fact, concerns the stable characteristics of the person coming to the health service. Analysis of the demand refers to the relationship which, thanks to the problem, the person establishes with the health service and with the staff he meets there.
With the diagnosis it is hypothesised that specific techniques of psychotherapy can be identified, which differ according to the different forms of the psychopathological nosography. The diagnosis, in this sense, serves to decide which form of psychotherapy to apply in view of the findings of the diagnosis. This approach is open to many theoretical doubts and great bewilderment in terms of scientific methodology. In spite of various optimistic statements on this, in fact, it cannot be proved on a solid empirical basis that the different forms of psychotherapy are efficacious in different psychopathological domains. This is because the technique of psychotherapies is not based on psychopathology but on the dynamics characterising the relation in the psychotherapy experience itself. Psychoanalysis, for instance, has put forward a classification of psychic disorders which is self referential to the analytical relationship and its aspects. So has systemic theory, with reference to the relations of couples or families. The psychotherapy theory that seems closest to psychiatric psychopathology is the cognitive approach, although it seems more like a superficial similarity, since this form of psychotherapy, too, has its own internal "logic" that disregards the diagnosis made for that specific patient. The different psychotherapies, in other words, have formulated psychodynamic or relational or cognitive hypotheses of the personality, consistent with the theory of technique applied in that specific psychotherapy.
There is also a second kind of problem that is interesting for us: the psychiatric psycho-diagnostic categories are used for the diagnosis of psychosis; but, since Freud, we have known that every person, even the non-psychotic, organises his adaptation and his thoughts through dynamics related to paranoia, depression, schizoid splits and psychopathology. They are "traits" that are more or less accentuated, present in each of us. If a psychiatric diagnosis does not aim to identify

serious forms of psychotic psychopathology, it risks giving labels - in certain respects correct but useless if not harmful - to common emotional aspects found in the whole "normal" population. By means of diagnosis, a specific tilt is given to the relation with the person coming to pose a problem to the health service: a relation that can create a sort of mimesis of the medical model, where the very act of diagnosing evokes a-critical dependence in the person being analysed and labelled, according to specific psychopathological categories. This dependence can justify a greater propensity to diagnosis in those who are trained in cognitive models: the cognitive intervention, often prescribing ways of seeing reality or models related to behavior, benefits from the dependency aroused in the future patient in the diagnostic phase.

Let us get back to the problem: as we have seen, this is a problematic emotional symbolisation of the events encountered in the course of life by the person making the demand. They are usually events that mark a change of context: the greater independence of a child for a concerned parent, a teenager discovering sexuality, an older person retiring from work, the risk of losing a job, a failure at school, conflicts in the family or the death of a loved one. We wish to be clear: there is no "typology of events" that prompts a demand; in fact, the demand is motivated by the emotional symbolisation of an event, a symbolisation that differs from person to person, even when the events are similar or the same. We have mentioned the "events" to explain what they are about, what is usually talked about in the relation of demand. But, we must repeat, the demand springs from the way a specific person symbolises a specific event. A mother who is happy with her autonomy, who valorises being content with herself, may be glad her daughter has become independent; a "worried" mother may see the teenage daughter's independence as a catastrophe. The point, however, is another: why does a mother, worried about her teenage daughter's autonomy, decide to go to a mental health service to deal with her anguishing concern? Don't think that the answer to this question can be taken for granted[2]. If the mother goes to a psychotherapist in the private sector - we are thinking of a psychotherapist with a psychological training – it is very likely that the mother's aim is to "entrust" the daughter to the psychotherapist. The mother might devote the first interview of demand to talking about the daughter, her problems, the risks she might run by facing them alone with no help from her mother, the rough, difficult friendships, a hostile context full of temptation, taking into account the weakness of the daughter who is easily influenced. These mothers often say that their daughter refuses to ask for the help of a psychologist, but they think the psychologist will know how to approach the daughter and convince her to do psychotherapy. Here the mother's feeling of impotence is obvious, and at the same time the feeling of omnipotence attributed to the psychologist.
The question concerns the motives that bring these mothers to the mental health service. The same question obviously applies to the many problematic cases that present their demand to the Mental Health Services.
One answer can be found in the fact that it is free, or that the public health service charges very little to treat the problems presented. It is well known that private psychotherapy is costly, while the public service is not.
The second answer may be related to the brevity of the public treatment, unlike private psychotherapy, which may last several years. Many people think that getting through the psychotherapy treatment quickly is a great advantage.
These two kinds of answer are apparently related to concrete problems of time and money. But one should not forget the symbolic dynamic that substantiates the factors motivating the demand

[2] In the case of mental illness, the breakdown of the collusion of living together, involving the mentally ill individual, is the reason for contacting the Mental Health Services. This often happens without the mentally ill person being aware of his problem and without considering it useful to go to a psychiatrist. In the case of the worried mother, the "problem" would seem to be in the mother herself and her anguish; not related to a breakdown of the collusion in living together. The choice of the mental health service should therefore not be explained in social reasons related to living together, but in the worried mother's need for someone to whom she can "confide" her problem. We will see that this need to "confide" conceals the fantasy of reproducing in the confidential relationship, an acting out to compensate for the problem experienced in her relationship with her daughter. For instance the mother's fantasy of being able to entrust the daughter to someone who can control her in the mother's place.

for public psychotherapy. First of all, the very nature of the demand: if a person goes to the psychoanalyst she expects to be “subjected” to a psychoanalytical treatment. If the same person goes to the public health service, she expects to have the problem dealt with independently of the treatment technique applied. What is expected then is greater coherence between staff initiative and the problem brought to the health service. This coherence can have two aspects: diagnosis, which colludes with the patient’s “medical” fantasies; analysis of the demand, which translates the demand itself into the relational dynamics established with the staff-member.
It is worth underlining that when the demand for psychotherapy concerns a specific technique (“I want to have the experience of psychoanalysis with you”) and the psychotherapist’s response concerns only the analysis of feasibility in the specific technique he uses, there does not seem to be any problem of diagnosis or of analysis of the demand. The demand concerns the experience of a certain technique and the response consists of applying that technique. These considerations may be thought too simplistic, but on looking closely much private psychotherapy follows this procedure.
In the public system, on the other hand, the presentation of the problem, considered in the sense of “problem” as affective symbolisation of an event or of an area of experiential reality of the person presenting the demand/problem, usually does not find a response limited merely to the application of a technique. On the issue of the impossibility of responding to a problematic demand by applying a specific psychotherapeutic technique, one could advance complex considerations of theory and theory of technique. We just wish to point out that the context of the health service limits this reproduction of the private sphere in the public sector, just as those bringing their demand to the public sector are oriented to expect the problem to be dealt with directly and explicitly. The question therefore concerns the way the health service treats the problem posed by individual clients.
In some cases one is tempted to see a close relation between diagnosis and treatment technique: we know that this relation has no epistemological basis. The psychotherapeutic techniques have elaborated, in the theory grounding them, a sort of psychopathology idiosyncratic to the theory of technique. This means that the different psychopathologies are not commensurable with each other: often one cannot even compare the dynamics that define and enable reference to be made to a specific disorder, for instance in psychoanalysis and systemic relational theory of technique. When one talks about paranoid personality for instance one thinks one is referring to a univocal concept but this term can mean different things, if it is used in psychoanalysis or in theory of the cognitive technique.
What we wish to underline is the necessary consistency between what one “understands” of the problem brought by the patient and the theory of technique that one intends to use for the subsequent or simultaneous psychotherapeutic intervention. If a psychodynamic theory of technique is used for instance it is totally irrelevant to make a diagnosis according to psychiatric parameters such as those laid down in DSM IV. We are thinking of a young woman who, at a public health service, presents the problem of being dropped by her boyfriend. If “being dropped” is related to the person bringing the problem, it may suggest the feeling of abandonment that can lead to a depressive dynamic. At the same time the woman acts out, in the relationship with the psychologist dealing with her, specific expectations: she must be the one to decide the dates and the frequency of the sessions, at times she does not turn up for the appointment or expects to change it at the last moment.
How can we look at the problem of “being dropped by the boyfriend”? What sort of problem is it? Yet again we are dealing with an event, not with the emotional symbolisation of the event. It is important to underline this difference. We can intervene on experiences but certainly not on events. But can we infer the experiences from the words used to define the problem (being dropped) or from the acted out experiences, in this case in the relationship with the psychologist of the health service? Do we tend towards a diagnosis of depression, concerning the person bringing the problem, or do we refer to the relational dynamic that the young woman established with the health service? Depression or expectation? Depression as an emotional reaction to abandonment or expectation as a dynamic of possession that the woman tries to act out in the relation of demand? The woman talks about her relationship with the boyfriend as a failed relationship, since she was not able to keep him with her. She says her affective relations have always been marked by reactions of jealousy, of often suffocating control, of which the man she is in a relationship with

quickly gets tired. The same thing seems to happen with the psychologist of the health service, who feels irritated and at the same time worried about this voluble, capricious, unreliable woman who is also tied in an entangling way to the therapeutic relationship. What relation can we establish between being dropped in a couple, and the depressive dynamic? Does one get depressed when one splits up with a partner? Or does one get depressed when one experiences “being dropped“ by the partner? Looking more closely, the two things are not at all comparable. “Splitting up” involves agreeing on the wisdom of ending a relationship, for the most varied reasons, and with the most varied degrees of participation in the “wisdom” of the decision. Splitting up at any rate involves a reciprocal communication and an acceptance of the “wisdom” of the decision. Being dropped, on the other hand, entails the one who feels abandoned having a feeling of failure of the collusive dynamic of control. If one feels dropped it means that the relationship was based on one controlling the other. We have defined control as a neo emotion organised by doubts, fears, diffidence on the part of the controller towards the person that is controlled or that one thinks one controls. Often the relationship of control is based on a collusive process where the one who controls, as well as the one controlled, gets pleasure from this modality of reciprocal diffidence and violence. The one who controls is violent because he thinks he can keep the other person “under surveillance”; the one controlled gets pleasure from making the act of controlling a vain, useless failure. But the one who is controlled also gets pleasure from the powerful image, free of any reciprocity, that being controlled confers on him. Whoever wants to control is motivated by an omnipotent fantasy, whoever is controlled feeds on a reciprocal omnipotent fantasy. In sum, controlling is a failure of the relationship based on exchange and reciprocity. Relations based on control are destined to end rapidly. The feeling of being dropped characterises those who expect to control the other person. So the person controlled, at the end of the relationship, may feel a sense of relief and “liberation”. Only to start again, seeking some other controlling partner.

It is understandable that the loss of the thing controlled and of the opportunity to control, can evoke feelings of compensation, where one seeks control in other relations, including that with one’s psychologist. If the psychologist is sure of the patient’s state of depression, she may overlook the attempts at control towards herself, for fear of “losing the patient” if she should question the expectations about the setting of the psychotherapeutic work. In so doing, she will merely cause an increase in the patient’s fantasies of control, creating with her a re-edition of what happened in the relationship between the patient and her partner. It could be said that the psychologist’s professional “masochism” acts as a prompt for ever new frontiers in the patient’s control fantasy. The dynamic of control is never satisfied and can go to extremes of behavior, such as the annulment of the other person or the annulment of the self. One way of simultaneously annulling oneself and the other person is a suicide attempt. We are talking about attempted suicide, not suicide itself. In other words, about the behavior that is the only problematic element for psychotherapeutic work. Improvement, worsening, declarations that one feels better or worse, thankful or concerned reactions from relatives and friends: none of these has a significance that shows socially the progress of a psychotherapy treatment. Suicide or attempted suicide, in contrast, seem to be events of unquestionable failure of psychotherapy, on the social level and on the level of the dynamics that such events are capable of evoking in the emotional life of those who are emotionally close to a person who kills himself or tries to do so. Suicide evokes, or is designed to evoke, eternal guilt, shame, disapproval and anger, impotence and a feeling of non-existence, plunging the people who were close to the suicide victim into a state self-annulment. These dramatic and devastating emotions can last for years, or be endless. But such reactions, as we know often from the requests for forgiveness by those who commit this act, are quite foreseeable for the person committing the “insane act”, and they are often what underlies the motivations that lead a person to take his own life. In attempted suicide, however, the person who tries to kill himself may be in relations that emphasise the dynamics of control taken to extreme consequences. A person who attempts suicide may have a feeling of triumph, in his need to control others, triumph in seeing the attempted reparation that “others” may make in response to the act. A person who commits an attempted suicide often throws down a challenge to whoever is looking after him, infinitely increasing his potential control.

We were talking before about the social *rebound* that suicide or attempted suicide may have in the domain of psychotherapy. This can be a particular problem in the case of psychotherapy in the public mental health service. Here the mobilisation may be general, also involving hierarchical

relations in the health service itself. Such alarm can affect the professional security of those working in the health service: suicide or attempted suicide, in fact, are dangerous events, felt to be threatening above all by the hierarchy; but they are also events about which little can be done to prevent This may mean restrictive measures, general caution, acting out of old conflicts between professional figures. This mobilisation, in sum, seems to be further evidence of the power of control that the act in itself embodies.
We have dwelled on this "case" to show how complex the psychodynamic form of demand presented to the health service is and how it can evolve in a few sessions of psychotherapy. We think that it is only with reception based on analysis of the demand presented to the health service that an intervention can be created corresponding coherently with the problem presented. It is a difficult job, requiring a specific theoretical and practical preparation, a job that clashes with the tendency to describe the other person using psychodiagnostic categories. Analysis of the demand, too, "is diagnosis", but with totally different methods from psychiatric diagnosis: focusing on the relation that reproduces problems, not on the psychopathological features of the "other" person.

Conclusions

One often talks about the users of the Mental Health Services, confusing the two great categories just described, of psychiatrically ill patients and those who bring a problem to the Mental Health Center. Remember that law 180 set up the health services in local areas to facilitate the placement in society or in the family of seriously mentally ill people, of psychiatric patients, and to cope with their periodic crises. Psychotherapy in the Mental Health Services is a recent breakthrough, based on multiple motivational factors and still not well defined in its strategic aims, in relation to the mission of the health services themselves. Psychotherapy in the health services tends to be accepted as a "fact", in the perspective that sees the health services in the local area as being open to everybody, with the idea that help must never be refused to anyone. Other times the psychotherapy activities in the CSM are seen as having a preventive role, the idea being that psychotherapy can prevent more serious forms of mental illness, with psychiatric features. Yet other times, psychotherapeutic activity is seen as a sort of evasion by psychiatrists (and then by psychologists) from the tiring workload, with no visible success in the short-medium term, designed to maintain the status quo in psychiatric patients. Yet other times the development of the private psychotherapy schools is pointed out, which took place in the Nineties: in these schools many health service psychiatrists have worked, bringing to the public services a demand that had previously been addressed to the private sector. Another hypothesis concerns the development of the psychology profession, which took place in the Mental Health Services in the '90s, after the passing of law n. 56/89 which set up the psychology profession, a development where psychologists (thanks to art.3 of the law) may have seen psychotherapy as the affirmation of a praxis that finally equated them in that domain to doctors/psychiatrists.
In all these justifications in hindsight, in our view no account is taken of the different relational dynamic inherent to the care of psychiatric patients on the one hand, and on the other, of the way of treating the demand characterising the people who bring a problem to the health services. The latter differ both from mental illness and from the private request for psychotherapy. Mental illness, we merely mention, originates in the failure of a specific collusion in living together. The mentally ill person, at times aware of this failure of collusion, other times unaware, is not bringing a demand for psychotherapy, or a demand for psychiatric treatment. The relation between the health services and the psychiatric patient often originates from the difficulty in getting the therapy accepted, whether it be pharmacological or psychological. They are two different dimensions, and we stress this, consciousness of one's problematic psychic state (awareness of illness) and acceptance of a therapeutic initiative of the psychiatric type, and therefore the demand for treatment by the mentally ill person. The mentally ill patient has great difficulty formulating a demand to the psychiatrist, referring to a specific problem: if the terms "demand" and "problem" are meant in the way defined earlier. The demand of a mentally ill person is usually acted out in social relations (family, work, friendship) which leads to the breakdown of collusion. When a mentally ill person approaches the mental health services, unless it is a TSO, it is difficult to distinguish how far it is the patient's own initiative, and how far he has been pushed by the family's advice, how far

it is due to resigned acceptance of strong social pressure for greater control over mentally ill individuals. That is why the diagnosis is important in the case of mentally ill patients: the diagnosis not only guides the psychopharmacological therapy or relational approach, but also sanctions the medicalising taking of responsibility of the patient. This reassures the social context where the breakdown of collusion occurred, about the identification of the pathology that led to the breakdown. Diagnosis transforms a social event into an individual feature, with a casual matrix, of the complex problem of the breakdown of collusion.
However, in the demand for psychotherapy things are very different. First of all in the "problem" motivating the demand it is not easy to identify an acted out failure of collusion. The demand for psychotherapy, on the other hand, is often designed to avoid a failure of collusion.

Let's try to explain this with two examples.
A man of about 50, married, employed in a ministry, has started to show strange signs noticed by this family, who are concerned: he tends to spend his whole salary on useless things; he is very argumentative and acts out with no restraint with his colleagues and above all with his office heads; violence with his wife and his elderly mother (a long-time widow in receipt of a small pension gained after working for many years in a lowly job for a small firm), considered responsible for his past inhibitions and his unhappiness; sexual advances to women friends but also to mere family acquaintances; disregard for traffic rules, with frequent accidents while driving his car. All this has been quickly transformed into social reactions to the breakdown of collusion caused by the man's behavior: in the space of a few months he loses his job, his wife asks for and obtains a separation, his isolation becomes more marked with the abandonment of friends and acquaintances; the only person who sadly accepts the new situation with sufferance is his mother, who takes on the upkeep of her son at her home. This man agrees to psychotherapy at a CSM, but he categorically refuses to take psychopharmaceuticals. He is confusedly aware that something is wrong, but his acceptance of psychiatric treatment is limited to some sessions of "psychotherapy" which, in his view, consist of a bit of commonsense advice and the chance to talk to somebody: this opportunity is offered to him by the psychologist where he goes once a month. Going to psychotherapy, according to him, is motivated by the need to keep his mother happy, in view of the man's scarce awareness of "being ill". The psychiatrist at the health service says the patient "refuses drugs": it is interesting to see the sense of impotence implied in this statement, and at the same time to see that the relational significance involved in the rejection of drugs is ignored. Accepting the medication would in fact mean that the man recognises the relation between the abandonments and the problems posed by his behavior; it would mean the acceptance of some causal relation between his way of acting and the isolation he finds himself in; it would therefore severely challenge his claims of being persecuted, claims which characterise his behavior towards the people he deals with, especially his mother.
It would be interesting to look at this case in more detail, but even a simple survey of it clearly shows the difference with the next situation.
The reception service of a CSM sees an elderly lady arriving accompanied by her husband, complaining of panic attacks. The woman has therefore learned the diagnostic terminology of her disorder in previous contacts with psychiatrists and psychologists: a patient arriving at the health service with a ready made diagnosis. In the first interview, the husband wants to be present. The woman remembers that, due to panic attacks, she often goes to emergency at various hospitals during the night, always accompanied by her husband. She gets to talk alone with the reception psychologist, and talks of a fusional relationship with her husband, in which she has the impression that he wants to intrude not only in her behavior, but also in her thoughts, fantasies and emotions. She is not sure of her own attitude: at times she feels she can't do without this fusionality, other times she feels tired and overwhelmed by it. The woman asks to continue alone with the reception interviews provided by the service, without her husband's presence. This is supported by the psychologist. The woman in question requests the reception interviews and acts out with a space for relating that is all her own; she asks to get out of the collusive dynamic based on reciprocal control that characterises the relationship with her husband. Soon, moreover, the woman starts a game of devalorisation of the interviews with the psychologist (she does not see the point, but anyway, there's no harm in them) and of fantasies on what her husband will be thinking, alone at home, while she has taken over the space of psychological interviews. She talks, though very little,

about a relationship with the husband that began in adolescence; about the only son who recently got married, leaving the parents alone; and of the need to control everything and everyone that she has had since she was a child. She thinks controlling is the only way to make sure she doesn't lose: her husband, her son, the doctor, her friends or the psychologist. Controlling has become her "obsessive" thought, ever present in her life. It is the first time she has spoken about it, she says during the reception interviews; it is a thought that she has always acted out, very often in collusion with her husband.

Looking at the two cases, one can see a profound difference characterising them.
In the first case the man's behavior caused a crisis in the systems of collusion in his area of living together: at work, in the family, with his friends, in the condominium where he lives. His loss is general, from work to his wife and friends. A real loss, that makes the man depend emotionally and economically on his mother, elderly and modest financially but also culturally. This is a person whose mental life has made him socially isolated and not self-sufficient. He finds his very limited participation in society thanks to his elderly mother, but in a few years time he will be totally dependent on the Mental Health Services and on the community that will have to take responsibility for him. This "state" of affairs seems to overshadow any psychiatric diagnosis. The diagnosis will help in setting the psychopharmacological medication, which our man refuses in the last-ditch defence of his claimed psychic normality. For the moment it seems enough to have some psychological interviews, rather infrequent thanks to the collusion between the limited resources of the health service he went to and the man's lack of interest in recognising and accepting his problem. Why? It could be said that as long as the mother looks after him the man's losses can be confined to his job and his marriage; the social system "does not feel the need" for any further initiative of taking responsibility. The fact that the mother will not be enough or will probably no longer be there in the work of containment in the short or medium term, will mean the failure of living together is not confined to the two areas of work and family. That is when the psychiatric taking of responsibility will start, with the well known circuit of TSO, SPDC, therapeutic and rehabilitation community, CSM, Day Center, to come back again to a TSO, an admission to the SPDC and so on.
In the second case, however, what we witness is not a breakdown in the system of living together, nor a crisis in the social system the woman is part of. With the woman's arrival at the CSM and in her reception process, she intends to act out the failure of a system of family control. Here, the relationship with the psychologist exhaustively "contains" the fantasy that motivates the woman to go to the CSM. Up to that moment she has used her "panic attacks" to exercise control over her husband and to feel correspondingly guilty. Now she feels the need to give up acting out and, albeit with the trick of separating herself from her husband through the "solo" sessions, actually forces a separation from the husband that allows her to think of her compulsive need to control, in order to have a relationship based on exchange with her psychologist, the only way to start thinking about her emotions. In this case it is the setting of the psychological relationship that enables the acting out to be completely contained and a relationship of exchange to be set up based on thinking.
One last note: it is not the psychiatric diagnosis that differentiates the two cases, but the analysis of the relationship between the person suffering from the disorder or problem, and the context: an analysis that affects the intervention by the health services as a whole in the first case, and that grounds the sense of a "psychotherapy" intervention in the second.

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