

“What story down there is awaiting an end?” Group work as a therapeutic function

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(...) three sources of our suffering: the overwhelming power of nature; the fragility of our body and the inadequacy of the institutions that regulate relations between men in the family, in the State and in society. (...) As for the third source of unhappiness, the social one, we take a different attitude. We don't want to admit it, but we cannot understand why the institutions we ourselves have created should not be a protection to the benefit of all. Thinking about it, if we believe that it is on this very point that the prevention of pain has proved even more unsuccessful, we start to suspect that here too some aspect of invincible nature may be hidden, that is, in our psychic constitution.
(S. Freud, *Civilization and its discontents*, 1929)

The individual always manifests some stable aspect of his personality (...). This stability corresponds to what I have called Institution.
(W. Bion, *Learning from experience*, 1973)

Introduction

We have been working for years at a Mental Health Service operating in a neighborhood of Florence. This service has been organised over the years in well-known points of the city that are in constant transformation and that now after years of work have become a part of our emotional and imaginative baggage. They have also taken on the sense of “mental places”, like those experienced in dreams or acted out as memories, located half-way between natural and cultural systems and triggering a process of individual and collective sedimentation in a society that leaves its trail on the ground. The space one lives in is one of the foundations of one's personal identity, and the home, just like the Mental Health Center, is the privileged place in our daily life organised around time, where there is order, certainty, stability and continuity. In short, the consulting room/home is a place for storing memories and experiences. Inhabiting, according to C. Norberg-Schulz (1979, p.34): “...means experiencing life as a multitude of possibilities. The sense of identification of one's home can be so profound that it is felt to be the symbolic extension of one's body, and likewise the home with its confines establish the distinction between self and others”. These are identity confines which each person needs to construct for himself, but that can become a trap tying the individual down to an life-story set in stone. Abraham Moles (1971), a social psychologist, identified a space perception set, which he calls “man's shells”: the first is the body, or what is divided off by the skin; the second is the gesture, the space of movement; the third is sight, the room; the fourth is the dwelling, the private space; the fifth is the neighborhood, representing meeting others.

Our service, in the place/neighborhood, has been organised over the years both as psychiatry for the local area and for the sheltered community. Local area psychiatry, which tries to contribute to the mental health of a community, features certain organisational and methodological strategies: a network of services and protections that are not just coordinated but almost integrated; a moderate “scientific” use of psychopharmaceuticals; integrated techniques in increasingly complex

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programmes; the valorization of personal relations with attention to the issues underlying symptoms; an expansion of the possibilities for psychotherapy; the use of intermediate facilities for treatment; the use of the normal resources of the local area for purposes of therapy.

Mental health community psychiatry introduces another element of knowledge and above all for therapy: group work. This ambiguous and purposely vague term can mean both the tendency to report to the group whatever the single staff-member feels and experiences, and a way of working in the treatment facility where the mental aspect recognises and constructs a space in a complex multifaceted area (Fasolo, 1994).

In such a kaleidoscopic field, talking about treatment in the official Facilities from a psychoanalytical perspective leads us to wonder how this can help to understand the facility, amidst the complexity of individual, group, organisational and management dynamics, interwoven on many levels, both real and imaginary. In the still common paradigm marking the psychoanalytical contract, the individual, private roots act as a defensive barrier against the “endless critical and emotional work that forms a whole series ranging from the individual intrapsychic dimension to the social and collective interpersonal sphere” (Petrella, 1981, p.500). It is this experience of the “plural” (Kaes, 1993) that distinguishes the Facility as a therapeutic workshop, capable of taking in new objects of study and treatment: the group, the family, and in particular, pathologies classed as “serious” that are often inaccessible for the tools used in the classical setting. The “plural” experience, part of the complexity of the institutional field, is supported by presence of two tendencies: one vibrant; the other violent and deathly, in a strictly codified reciprocal presentation involving a sort of compulsion to repeat. This experience is common to all the Mental Health Centers.

Group work in our experience is the way our service operates, offering the patient and staff the chance to experience diversities, constructing group psychic spaces, where shared experiences can be symbolically re-elaborated. Group work can therefore be seen as the transformational role of the Facility.

Increasingly in sheltered community psychiatric services, there is the need to construct conceptual tools to define and assess the group and institutional factors that work, change and are concealed in everyday therapeutic practice. The definition of this set of tools finds a very strong stimulus in the way the public health organisation has been rapidly and often wildly turned into a business. This has radically changed the institutional field and the dynamics it involved and therefore the traditional concepts of psychodynamic knowledge, of psychological reading of the individual, group, or community dimension must be constantly subjected to criticism to avoid taking a “finger for the moon”.

We are going through a period where the “business” aspect of the mental health services has led the idea of organisation to lose meaning and to be interpreted as the attempt to control or hide the individual nature of the staff-member exposed to serious pathologies and where phenomena of transference take on a special loaded sense in the individual-group-facility sphere. As Arrigoni Scortecci (2003) succinctly puts it, the use made of the organisation is often avoidant and phobic, to escape from the anxiety of the individual responsibility of accepting a profound dependency, without making a distorted narcissistic use of it.

The “famous” business transformation has revealed more and more not only its institutional constraints, but also the set of procedures that the services feel to be a persecution: cramped spaces, precarious funding, forms to be filled, and the information system. Unlistened to demands are made, where there is a “syncretic” (Bleger, 1992) fossilization of outdated individual or group aspects, both building up an amorphous parasitic area that tends to perpetuate the organisational aspects most resistant to change, and amplifying the original disruptive demands (envy, exaggerated conflictuality, manipulation, etc) which convey impotence and “paranoia”: this is how any collaboration in the functioning of the mental health services is attacked and undermined.

In this climate of team work, as described by Marta Vigorelli (1994), there is not only a mental state to coordinate, but an actual organism to keep alive. So the tired futile contrast between organisation and culture in the carer groups is overcome in a global synthesis of the operation of an institutional group. This is true also for the therapeutic community, “the Care Home”, whose

therapeutic and iatrogenic factors are linked both to the individual mind and to the group dimension, to the time passing, to the continuity and cohesiveness, to the crisis and breakdown of sense of self and its relationship with the universe of family and social meanings. In the services, dealing with this contradictory aspect allows us to understand why a patient with psychotic borderline traits needs a community not in the generic sense, or why in the chronicity of self-representation of the divided self, it is the only area of shelter and a place where the patient feels he can live.

Some words, bridges between differing knowledges, are always with us when we think about these issues.

Institution: describes anybody, formed in the past, of social grouping with overall aims concerning the existence of individuals. In a psychodynamic perspective, it is conceived as the outcome of the process of collectively constructing and sharing symbolic relational models.

Field: a concept generally understood as “collection of strong fantasies, emotions and shared images”, undergoing constant evolution and transformation. An example is the concept of field applied to institutional psychiatric groups working in the local area, which Antonello Correale sees as deriving from his personal reading of K.Lewin’s field theory. He is therefore moving parallel, though with different original nuances, to other authors, both Italian (Corrao, Neri, Barnà) and foreign (Willy and Madeleine Baranger, Bleger, Jacques, Kaes, Anzieu), who have referred to the same concept during their psychoanalytical reflections both at the individual and the group level. For Correale the field is therefore “the overall set of mental factors working in the group, with its specific connotations of emotion, climate and atmosphere”. And again: “An area of phantasms, ideas and shared experiences, a scenario, a narration and not a role play” (1991, p.43). With reference to the treatment of serious patients, there arises a shared field where the plurality of the figures on the one hand makes it possible to dilute and differentiate the marked affective investments, while on the other hand it may enable internal dynamics to be acted out and focal points of suffering to be understood.

Working group: “...not only a sum total of roles and functions, but also like an actual group field of experience, affects and shared representations, endowed with its own history, its affectivised memory and its shared project-making capacity” (1993, p.143).

In this article we look at the institutional group, showing its role in the care of serious patients, referring to the basic therapeutic factors which are, according to Correale always present in the group as such, independently of its specific type. These are therapeutic factors that, while having different modes of expression, affect the common good, namely the sense of cohesion and continuity of the self, so seriously threatened in the majority of psychiatric disorders.

From Care Home to Therapeutic Community

The issue we want to deal with is the impact of serious pathologies on the group of staff in a Care Home transformed institutionally into a therapeutic community in which clinical discussion group work has been set up in order to restore “areas of thinkability”.

The question we started with is whether it is possible for the field of the community’s small working group, and the institutional global field where the facility is located, to take on the features of a system for transforming and elaborating emotions. In other words, whether it is possible to “think” in the institutions, not only as an individual but also as groups, and to consider this activity in itself a curative factor.

This question, left open, has been under scrutiny since the beginning of our work, also through the experience theorised at length by Sassolas (2001): residential facilities can assume a transformational role if they guided by thinking about their operation, and therefore by the possibility for all the participants in the treatment system have a psychotherapeutic function and there is a space where action is suspended where the staff feel justified and free to think about what happens amongst themselves, among the patients and between them in meeting.

The Therapeutic Community is a functional concept referring essentially to the possibility of using the resources deriving from living together in the therapeutic intervention. However, a therapeutic

approach centered only and immediately on mental activity risks triggering mechanisms of attack or flight, the patients moving on a psychotic register develop strong suspicion of their own mental activity, which is then unbearable, dangerous and painful. In this sense, the group field that emerges is the transit between Care Home and therapeutic community, along with the introduction of the function of “clinical discussion work”, an intermediary between carers and patients, can first of all offer the chance to sooth, reassure and revive the patients’ psychic life. The community can also be represented as a sort of “no man’s land” between everyday life and the psychiatric universe, a substitute living place where there is neither the hospital nor the family, nor their distorted representations.

This place, in the figure of the staff-members, also has the advantage of being a third subject between therapists and patients, and can therefore be fundamental in constructing a therapeutic relationship and in keeping it going. Moreover, in the “domestic” aspects that the community offers patients – with its everyday actions (preparing meals, tidying up, routines, timetables, etc.) – there is the opportunity to meet other people, reducing the danger, and the relationship with the staff in concrete everyday life can enable some repeated habits, often sterile lifeless rituals (drinking coffee, smoking etc.) to be transformed into surprising, vital experiences. The accommodation thus takes on a therapeutic role if it is seen as a means to pursue a pathway, not just as a roof over the patients’ heads confirming their chronic state, but a way to promote the weakening of the psychotic processes that keep them prisoner. As in all community facilities, the house is also a place where the psychotic scenario is actualised, because its basic characteristic is represented, as Sassolas says, by externalisation, that is, the expulsion of one’s mental content into external reality, which is the only possible way to free oneself of thoughts and emotions. Sassolas himself divides the experience of Villeurbanne into three elements: the personalisation of relations, each patient’s membership of a small group, and the immersion of this group in the reality of a place and an institutional setup that is easy to decode. These patients’ inability to live out the conflict on the register of representation and verbalisation, and the resulting expulsion of the conflict into reality, gives the chance to face the central core of their psychopathology in ordinary real life. So the institutional situation can also be exploited to make dynamic diagnostic hypotheses (one staff member used the concept of theatre as a metaphor to represent the community, being the place where a script can be constructed to put into words). If we then think that the community in its care home dimension echoes the earliest family relationships, its everyday nature can provide valuable information about the intertwining that develops between the patients’ psychopathology and the staff culture. The idea of the community as a family facility is not just an abstraction, it is the everyday experience of all the participants involved. The doctors are often recognised as having a parental role and relations among the patients are similar to those among siblings, with rivalry, envy, jealousy, and the search for affection and protection. In most cases, these feelings and conflicts remain completely hidden with defensive behaviors until they are recognised and legitimated and it is precisely this work on everyday life, observed and examined by the staff, that enables the patients to live an experience of affective relationships that are not intrusive and destructive.

The greatest difficulty for those who work in close contact with serious pathologies is certainly the invasion of one’s own psychic space by overwhelming primordial emotions. The term used by Sassolas, “transplant of emotions”, gives a clear idea of the psychic violence we agree to be subject to in a close relationship with these patients, but also the possible phenomena of rejection. After all, this invasion is not just a difficulty, but also perhaps a means, often the only one, to allow a restitution of meaning in a form that is processed and acceptable and therefore can be taken in.

The experience.

We will refer to some clinical situations taken from our work with the staff, the processing of which enabled us to become aware of some experiences concerning both doctors and patients, but which also had a fundamental meaning for the establishment of the working group recently set up. The reflection started from the experiences of the staff with the behavior of a patient, Carlo, who “leaves cigarette butts all over the house and makes a mess”, as if he wanted to spread fragments

of himself around. The conscious and unconscious aim of this behavior is not necessarily to attack and annul the staff-member (initially the patients' destructiveness was felt to be a personal attack, and making a mess was felt to be intentionally aimed at the staff, to oppose their desire to keep the place clean), and we also observed that some of the staff seemed to react like a mother offended by her child's dirtiness and neglected state. In this case, the patient's confusion and fragmentation is externalised in the house and the therapeutic function involves the capacity to tolerate, in the patient's place, his distress and desperation (his dirtiness and body odour), the verbalisation of his rage and the discouragement on the part of the staff. In their meetings with us this certainly had an impact on the patient, as it was linked to tolerating the fact that he was subjected to psychotic investment. If we deny the phenomenon of externalisation, we risk treating things that are the receptacle and vehicle for the patients' psychic problems as pure reality.

We will also try to underline the importance of performing actions that have a meaning ("talking acts", according to Racamier (1982), encouraging a reflection on how far even the most trivial daily actions are able to talk to the patients, giving them a meaning of their living in the facility. The use of the real is a sort of acted-out language that completes or replaces spoken language. The disorders of symbolisation characterising psychotic functioning lead patients a talk through actions and pay more attention to our acted-out messages than to our verbal ones.

For instance, concerning the neglected state of the house and the filth, often pointed out by the staff as the critical factor in their work, concrete acts like helping patients to clean up so as to promote the ability to take care of themselves, are an acted-out message that conveys care and which, accompanied by "talking", such as wondering about what is happening in the house at a particular moment, can allow an initial form of elaboration. As with the patient Carlo, the fact that the dirtiness problem was handled through the experience of a staff-member (assigned to him for this), made it easier to slightly reduce his confusion.

The issue of dirtiness initially also concerned another patient, Sara, a young woman living in the community in a state of isolation, always in her untidy, dirty room, which severely challenged the staff. Here the filth and mess seem to be related to forms of what we could call accumulation, perhaps of memories, through the collection of newspapers and a variety of things, as if it were a sort of hoarding addiction. Moreover Sara was perceived by the staff as exaggerated and excessive, and emphasis was placed both on the radical glaciation of time experienced with the refusal to let herself be helped and the temptation to respond with total care, as well as the staff's feeling "like a garbage bin" that must be able to contain all the rubbish of the distress that Sara "vomits". The experiences with Sara range from a strong desire to care for her, through admiration for the complexity of her mental products, to anger and the desire to expel her. However, an important initial aim was achieved, when after instances of rejection and repeated running away, the patient agreed not only to stay in the community, but to live in it, almost as if to allow herself to experience the care home. Achieving this objective can be connected to the fact that the staff had found the right distance from the patient.

In these initial observations what the staff say seems to suggest a sort of painful feeling of the physical and bodily aspects tied to the physical needs of these patients; after all, being immersed in the same context for many hours of the day can evoke in the patient the need to have the staff totally at his disposal, having their undivided attention and the fantasy of finally being able to "fill" them with a mass of unfulfilled demands of all sorts. Such needs and fantasies prevent the staff member from being recognised as a professional, and when the exaggerated requests are naturally not satisfied, the patients tend to denigrate their presence and their role, as well as the role of the facility. One particularly important aspect stressed by the staff is the desire on Carlo's part to use them as a substitute for his lacking mental and affective functions. The staff's narcissistic sphere is stimulated and they let themselves believe that the patient cannot do anything without them, tiring themselves out in making up for his deficits with a reparatory attitude. The patient feels this to be rather an intrusion, or an attempt to imprison him against which he defends himself by increasing the degree of isolation and passivity, at times with aggressive behaviors, thus setting up a vicious circle. The establishment of this vicious circle makes it clear that the staff are exposed to two opposing risks: abandoning the patient which destructures him, or being over-protective, which diminishes him. There is the need to mediate affectivity and affectionateness, for example in the case of Angelo, who tends to make continual requests to belong and to be helped, but also complains that he feels suffocated by the staff's "hugs".

The contradictory nature of the requests and having to accept dependence – at times even having to stimulate it with affectionate behavior, only to then withdraw when this risks becoming more personal and sexualised – are other crucial aspects.

One cannot but agree with Correale when he says the fatigue that predominates in the mental health services – fatigue that we often tend to attribute to bad organisation and scarce resources – is also linked to the “anguishing fantasy of being inexhaustible” that mental illness evokes in the staff. One gets the impression that one of the fundamental aspects in the historical field of this staff group is the lack of limits, in the sense of expectations of omnipotence concerning one’s own resources and the possibilities of “recovery” for the patients in the facility: it is as if the patients stimulated an omnipotent part in the staff connected to the narcissistic investment that the latter make in themselves and in the facility. This narcissistic care shown by the staff is often linked to the fact that their professional ideal and their self-esteem are challenged by the self-denigration of the patients. The sense of impotence and uselessness faced by the staff is due both to the comparison between the results obtained or obtainable and the idealised expectations, and to the comparison between the idealised professional image of themselves and a more realistic analysis of their own resources, limits and constraints.

Staff dealing with serious patients tend to transform their acts into a routine, where the professional character covers the unconscious unwillingness to get involved in the therapeutic task and even the unconscious sabotage of the treatment process. The group of staff and the patients’ families can establish unconscious secret complicities which are expressed in various forms of resistance and symbiotically adhere to the pathological needs talked about by Boszormenyi-Nagy (1962). Discussion work enables them to start to become aware of these limits and deal with them, elaborating, as it were, the mourning for their imagined omnipotent capacity. The staff’s high expectations are well matched (unconscious collusion) with the patients’ expectation of being totally, unconditionally taken in, given their passivity, their withdrawn position and at times their blanket opposition to what the services offer. The problem is to understand “what” the community is in the treatment process and to what extent it can be inhabited/expropriated by the patients, what limits the staff can place on their aims, on themselves and on the relations with the patients.

Metaphors.

We must mention some metaphors related to the representation of the community, used by staff in the course of elaborating this discussion group. In the narrative steps during the various meetings, these metaphors enable us to see some transformations of meaning. For instance, from the image of the “vomit-room”, they went on to that of “on the road to nowhere”, where chronic patients remain stationary, and from this to another later metaphor that is especially telling, namely the image of the community as a “station”, where, the staff-member says, “the passengers arrive from different directions, stay there together and can then find the right train to catch”. In this phase, the group also produces the image of the “container” as a metaphor of its therapeutic role. Here what struck us was the image of the station, undoubtedly the most evocative, as a place of arrivals and departures and therefore of meetings and goodbyes and obviously of the related anxieties, which may be aroused by meeting another person or by separation.

In one of his last works, “If one winter’s night a traveller”, Calvino writes that arriving at a station can give you a sense of a return to the past, of re-occupying lost times and places, or it may bring a flash of lights and sounds that make you perceive you are alive today. This metaphor seems especially appropriate for a therapeutic community. The station – in Calvino’s words – is also the place where you can leave your baggage, where bags might get mixed up, but also where personal possessions are shared, as on trains. We metaphorically compare our community with the meaning of this work which begins in a railway station. The novel does not tell a complete story, but instead talks about the impossibility of writing a conventional story with a beginning and an end. The book is in fact made up of ten beginnings of novels, which for various reasons are destined to be interrupted. Every unfinished novel has a title. The surprising thing is that the titles of ten unfinished novels, or rather of the ten beginnings, put together one after the other make up a poem that has meaning:

“If one winter’s night a traveller
Outside the town of Malbork
Leaning out over the steep coast
Without fear of wind or dizziness
Looks down below where the shadows gather
In a network of lines that meet
On the carpet of leaves lit by the moon
Around an empty grave
What story down there is awaiting an end?”

Just like the unfinished stories in our community, when they are put together, they can form something whole, although it is obviously a meaning that refers to something else and there is always a question: What story down there is awaiting an end? In short Calvino refers us to the possibility of shifting from stories about origins to the origin of a story, as it were. All this is related to the underlying idea of the Group and of the Community, that is, to the possibility of starting stories, about the group and the community, that ask questions about waiting for the end, using as a departure point the unfinished stories of the single individuals. Certainly, the possibility can be seen in many ways, but that of understanding, looking “around an empty grave, with no fear of wind or dizziness – what story down there is awaiting an end?”, seems able to fit the aims we set as members of a group, with the need to approach the inevitably elusive core of the patients’ story and also to signal the possibility of swinging between “patience and security”, useful characteristics according to Bion (1970) for those in a helping position.

Conclusions

Thinking of the history of our community and its origin as a halfway house, what seemed crucial to us was the concept of “taking on the patient” as one of the fundamental factors from the therapeutic point of view, which covers the patient’s living conditions, his bodily operations, the prescriptions for treatments to sooth or solve, in other words his therapeutic plan. Racamier (1982) tells us that it is not easy to explain the “soignante” function, but meanwhile we can start by saying what it is not and what we hope it will not be. It must not be a prison, even though the patient needs to be protected. It should not be a disguised kindergarten, where the patients’ extreme dependency and infantile regression are stimulated. It is not advisable for treatments to be exaggeratedly technical, either in emptying them of dynamic psychological contents or in expecting to assimilate them to a psychoanalytical function. Racamier sums up by saying that the “soignante” role is practised “at the patients’ Ego level, in particular in the aspects of the Ego that are not usually listened to by psychoanalysts when practising psychoanalysis”, The basis of institutional treatments therefore lies in being present and helping the patient’s Ego.

We wish to stress the idea of “presence”, as conceptualized by Nacht (1963). The main function of many of the manifestations and symptoms of psychotic patients is to remind us of their presence and to call for ours. Dependence frightens them, because they experience the object as destructive and devouring, but absence is transformed into loss and destruction. The “soignante” presence must be stable, available and not suffocating. For our patients this presence is as relevant as the need for institutions designed for them, permanently available but with a special quality: many anonymous, uncoordinated faces make up a crowd not a presence. On the other hand, a therapeutic community has an aspect of being simultaneously generalised and personal, multifaceted and coordinated, providing a permanent stable background against which each personality becomes recognisable and therefore tries to reorganise and restructure himself.

In the staff’s thinking in our community, the greatest difficulty emerging was that of defining the acceptance of the patient. This does not consist of simply identifying with him and taking an active interest in him, but dealing with his psychotic experience. The staff must take responsibility to: 1) “free him” from the mental and emotional functioning that has him trapped. The patient, not having been able to establish a healthy dependence on an object that can develop the resources typical of the Ego, has structured a pathological dependence on an internal object that makes him ill or mad, a bad object according to Fairbairn (1992). Therefore, as Guntrip (1993) says, when the schizoid manages to start relating with real people, he reacts as if they were identical to his bad inner

objects and so tends to enter compulsive mental functioning, configuring a vicious circle of aggression-guilt and blame, from which he must be freed; 2) establish with him a relationship that enables him to use the interpersonal context as background to the therapeutic process; 3) be able to accompany him in the steps of this process through progress and regressions, and anticipate, as far as possible, his needs to prevent him from slipping into anonymity in the community, like a ghost, trying to avoid observation of his secret life, where he hides both the most pathological aspects and the more undeveloped ones that are more primitive and healthy. If a patient strays away from the therapeutic process, it then becomes necessary to pay him attention and bit by bit find a way into this secret dimension. Daily gestures, like knocking at his door to ask how he is, showing him we have thought of him, going to visit him, letting him understand that for us he is important and that he is present in our concerns, are experiences that he may never have had before. So in the final stages of therapy when we can understand in their entirety the factors affecting the illness and the patient can deal with the pain present in his life not only with authentic sadness but also with a new ability to elaborate the stages of the illness, it is when he will be able to do without aggressiveness towards himself and others, to feel emotions without disguising, denying or dissociating them. It a painful time, but it is here that the patient and the staff feel the hope of recovery.

These functions shared by all the staff, must be assured personally for every patient taken on, because the community often scotomizes the personal aspect. The therapeutic community really functions in an integrated way when the set of people living together in the same place, with different roles, share a common task. This task presupposes both a certain "confidence" that through this therapeutic community-based process the patients' mental functioning can be modified, and that accepting our limits and those of the patients is not too frustrating, as well as the ability to modify our rigidities and mental patterns with a good dose to tolerance and patience.

Problems related to living together arise in any group of people who come together and therefore also in the therapeutic community, where there are two decisive, specific variables: one depends on the degree of coherence of the theory and working methodology of the therapeutic group, the other is "burnout" in the daily contact with patients which triggers powerful mechanisms of transference and counter transference, continually challenging and provoking the therapeutic group in its fundamental aim of maintaining a psychotherapeutic balance.

The interweaving of expectations and idealisations, of rebukes and requests, of misunderstandings, of great illusions that can be transformed into bitter disappointments, of intense needs often frustrated because they are not recognised, is an intricate fabric from which those in charge of the community must be able to bring out the best things, always running the risk of something escaping their control or of the worst happening.

Lastly, we will look again at the unanswered initial questions: is it possible to "think" in the institutions, and consider this activity a curative factor in itself, in the case of serious pathologies?

Can the structure we have described as a stable organism be thought about and how can we make it become an evolving object of treatment? What kind of expansion could an experience of this kind have, being based on the possibility of keeping thought alive in the staff's minds, as a way of encouraging the painstaking work of resubjectivisation that marks the therapeutic process of psychotic patients in sheltered communities?

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