Three sketches for a portrait.

by Vincenzo F. Scala*

In the economy of the Department of Mental Health, the Mental Health Centre is the main place where citizens and the public health service can meet and interact concerning all those situations and needs related – in the public's interpretation of the term – to the sphere of mental health. The hospital Psychiatric Service for Diagnosis and Care is the other possible access point to the Department, but only for conditions that are urgent in that they constitute a danger to oneself and others.
The Mental Health Centre, which should be a facility always open to the public, receives a varied and substantial range of demands, consistent with its initial underlying mission and with the transformations and expansions it has undergone over the years[1].
Today, the managers and administrators believe by and large that the so-called "core business" of the MHC and of the entire Department is made up of the assistance needs of the users that, from the "ex iuvantibus" viewpoint, used to be sent to the Psychiatric Hospital. But it is recognized that alongside this type of client, there are many other kinds of needs and demands. For instance the whole large area of so-called "common emotional disorders" or "common mental disorders". On this point, a recent extensive study[2] reports that 7,3 % of the general population say that during the past year they have suffered at least once from something that falls into this category. Then there are a series of situations that cannot be considered common, but that do not display levels of dangerousness or obvious deviance from the norm such to be considered "core business", and that anyway are associated with great difficulties and acute suffering for those presenting them (think for example of what is currently said about the progressive increase in the occurrence of borderline personality disorder). This complexity in the demand directed at the MHC inevitably reminds us of the need to diversify the responses that the service offers and the interventions it implements.
And what about psychological competence? How is the psychological competence present in Mental Health Centres – to varying degrees depending on the different regions of Italy – implemented in this panorama and what could it offer that is new?
We will try at this point to outline a possible, partial operative plan for psychology in the MHC, through the presentation of three short reports, or rather sketches, of three clinical situations. Each will bring up points that prompt reflection.

The Emigrant
The Emigrant is a young woman of thirty. She comes from a town in Calabria[3], were she left her parents, a slightly younger sister and her maternal grandmother. It is an old-fashioned family that scrapes by, living in an old, cold house where family relationships are based on the need, mainly embodied by the mother, to stay all together and united.
The Emigrant came to Rome to University and graduated, was not able to transform her training into a productive activity, but decided to stay in Rome anyway. In doing this she resisted the call of her family who want her at home, doing what is unclear, even doing nothing, but present in order to share the relationships and the family difficulties.
The Emigrant saw her future as a Calabrian woman, either staying in the original family circle or taking a path already mapped out, like so many of her peers who, sadly in her eyes, had become wives and mothers.

* Psychologist in the Department of Mental Health, ASL RM/B
[1] For a description of the historical and cultural process from the beginning of the Mental Health Center to nowadays, see Paniccia, Di Ninni & Cavalieri, 2006, in this review).
[2] It deals with the Project ESEMeD-WMH (European Study of the Epidemiology of Mental Disorders – World Mental Health) carried out between 2002-2003 in six European countries (Belgium, France, Germany, Italy, Holland and Spain). In Italy it was managed by the Superior Health Institute.
[3] Italian region

She therefore chose to escape from the circle that was closing around her, but her trajectory from a familiar place with its boundaries inexorably staked out, took her to a place of marking time, a non-place. Though it was clear what she wanted to escape, in this state she does not know where she will and can arrive.
In her emigration something has changed, but something else has remained the same.
In her family, in the town, the context was univocal and insistent in pointing out the direction to follow; in Rome, on the other hand, she can decide her own destiny, but she is forced to face the constraints of the new situation (the cost of rent, the possibilities of making a living, the way to link her training to a job…).
What has not changed is her model of relating with the world, with the context; this is still based on passive dependence. This model was useful in orienting her in the early stages of her life in Rome, when she was at University, but when her studies finished it became totally inadequate, since the aims and the paths to achieving them are no longer predefined, there are no safe instructions to follow.
This led her to approach the Service, for signs of depression that she fears may sweep her away as it has in the past.
And therefore psychotherapy, as the place in which to pour out her disorientation, uncertainty, sense of temporariness, anxiety about a life based on a job she took for lack of anything better but that she considers below her original aspirations, now fading (she works as a dental nurse in two different dentist's rooms and she has a degree in scenography), and about the constant difficulties of sharing a flat with other girls chosen by the landlord, and who often change over. She also has precarious affective relationships, like the confusing, clandestine affair with one of her employers.
Psychotherapy as a place of denunciation, of complaining, of declared impotence…of reproposing the old model.
But psychotherapy also offers the possibility of starting to acknowledge all this; an opportunity to transform a vision of reality in which everything is the same as everything else and everything is in chaos, into a vision that establishes distinctions (dentists are not all the same, what happens on one dentist's rooms does not happen in another…), that identifies space for possible action.
This is a non-linear process which, at the moment, accommodates swings and back-tracking.

It is commonly thought in Mental Health Centres, and supported by data from information systems, that of the new demands that arrive at the Services, about 30% is related to what is generically defined the "serious" area, including conditions related to schizophrenic psychoses, mood disorders (bipolar disorders and major depression), and to psycho-organic syndromes. 70% of the demands, on the other hand, refer to conditions covered by the category of "common mental disorders" (anxiety disorders, minor depression, eating behaviour disorders, tendency to alcohol abuse) or by that of moderately serious personality disorders.
The area of "common mental disorders", in particular, deserves consideration from the point of view of psychological competence. In fact, if these conditions are considered from the standpoint of acute symptomatology and observed through the lens of psychopathological classification, they refer to the diagnostic categories mentioned above. But if they are read in a psychosocial key, they appear as difficulties of persons in relation to contexts of life and of changes, desired or unwanted, foreseen or not, which suggest to those involved the need to identify lifestyles, positioning, relationship modes etc. that are new and different from the tried and true systems each person adopts[4]. In this perspective the symptomatic aspect moves into the background and acts as a signal rather than the central focus of attention and target of the intervention. These are therefore questions on which psychologists have more than a little to say.
However, it is often said that to avoid weighing down the psychiatric services, it would be useful to get GPs to treat this area of problems with the use of appropriate psycho-medications and general support. Evidently these are two perspectives that can hardly be considered equal!
A problem certainly arises if we think of the data mentioned earlier. The study cited indicates that in the twelve months before the interview, 7.3% of the general population supposedly suffered from one or more common mental disorders. It should be specified

[4] In this respect, see the construct of "collusion failure" in Carli & Paniccia, 2003.

that in this study the disorders considered were depressive disorders (major depression and dysthymia), anxiety disorders (generalized anxiety disorder, social phobia, specific phobias, post-traumatic stress disorder, agoraphobia and panic attack) and the disorders related to abuse/dependence on alcohol.
A MHC acts as a reference point on average for populations of 150,000 – 200,000 inhabitants (for the over-18 population band). It is therefore clear that "common mental disorders" constitute a substantial, critical phenomenon for a service whose purpose is the care of the mental health of a given population. So far I would say that this critical nature has been dealt with by saying only in an undertone that the Mental Health Centre can be a place where demands related to this area can be referred, permitting only a minority of the population to be informed of this. Some services, then, tend to actively discourage this type of demand. And also the physical characteristics of the facility (location, quality of spaces …) at times act as an effective filter.
Moreover, at the moment, before the awareness of the size of the phenomenon and therefore of its importance in terms of public health, there is a lack of interest in examining it more thoroughly, as would be necessary in order to take appropriate action.
If we take the hypothesis mentioned above about the origin of what goes under the label of "common mental disorders", we can imagine that, in the population of all those who in the last twelve month have suffered from at least one disorder, a part is made up of people who have been able, alone or with the help that can be found in living contexts, to find a solution and recover from the "disorder".
We also know, from direct experience of working in the services, that for another part of that population this does not occur and qualified help is necessary, as happens in the numerous demands that reach the attention of the Mental Health Centres. And here we must wonder what the outcomes are when, in cases of such a need, qualified help can be found, or due to lack of information or unavailability of services, it cannot. In particular, what happens when the people remain indefinitely entangled in problematic situations from which they are unable to find a way out?
Lastly, there certainly is – and this too is witnessed in daily experience – a percentage of situations in which the emergence of a common mental disorder is an opportunity or even an excuse to focus attention on the interlocutor, or place on the table non-contingent issues, tied to the stratification of the experiences during the history of those involved, starting from a very long way back (and this may bring up the question of personality disorders).
We do not know however to what degree and in what proportions these different possibilities are present in the experience of that 7.3 % of the general population we are talking about.
What is certain however is that for a more decisive acceptance by the Mental Health Centres of the question of common mental disorders, there must necessarily be the identification of strategies, modes of intervention and development of appropriate operative tools. And on this point the professional component in the services – including psychologists – is lagging behind in its thinking.
With reference to the context of which I have personal experience, I have had some ideas at various times. As far as psychological competence is concerned, an idea would be to refine the capacity to recognise and deal with those situations where a brief intervention based on the identification of a contingent problem can represent, for the client, a meaningful and effective service in restoring his capacity to constructively confront his own experience. One gets the feeling, instead, that at times in situations of this kind the treatments implemented are long-term, not useless, but perhaps not strictly necessary and constituting a product that it is not appropriate for the service to take on. In contrast, in some services, the response that may be given to situations of this sort equates to essentially conveying to the client that by approaching the MHC he has come to the wrong place.
But there is no doubt that the psychologists in MHCs are presented with a whole range of situations where a brief intervention (let's say within the five meetings envisaged as

the assessment phase) would be pointless and it is necessary to take a medium to long term perspective, which raises the issue of the requests/available resources ratio. And here a more purposeful, organic use of external resources could be considered.
It can be observed that while on the one hand the Mental Health Centres are under pressure from the public's demand for services, on the other hand they receive pressing requests from private psychotherapy schools and the university schools of specialization for the running of practical traineeships. In the MHCs there is a wide range of professional psychotherapists – psychologists and psychiatrists – with 25–30 years' experience, who could use a part of the time devoted to clinical work with the public to the role of supervision. It would not seem to be out of the question to combine these different elements and create facilities that provide a service to the public, provide a training context in the field and produce research on praxis.
In a perspective of community intervention, one could also think of an active role of Mental Health Centres in promoting the model of self-mutual help in the meeting places found in the area.
These are hypothetical initiatives that are often considered, but which so far have not been implemented, even as an initial experimentation, due to the lack of the necessary creative energy and decision-making power.

The Self-Sufficient Individual
In 2001 when we were advised by letter that his mother had died, leaving the Self-Sufficient Individual alone, he was already well known to the Service. He had contacted us years before, already an official invalid and entitled to the pension; the report said :"dissociative syndrome".
But what mainly characterises him is a sort of obstinate and almost infantile need to oppose the interlocutor and escape from the constraints governing contexts, always having in some way to bend the accepted, shared rules at least a little. This deeply-rooted attitude has led him to a state of relative social isolation. With two exceptions: his long-time relationship with a friend from high school and his family; his interest in the glittering world of the opera and classical music where, in some circles, he is welcomed and accepted as a mascot, and can thus enjoy some privileges like free tickets for important artistic events.
In past years he has taken part in numerous rehabilitation initiatives, during which the attempts to reconcile self-sufficiency and participation in the context, ended punctually in blunders of varying degrees of intensity. The same happened when for two years he attended a day centre for pre-job-training which did not have the desired outcome of launching him into a productive role.
The person who advised us by letter was his friend, a person of great social commitment who for the Self-Sufficient Individual, plays a role that could be defined as "public relations spokesman". In the letter he underlined the role that he expected the Service to take on now that the Self-Sufficient Individual was facing life alone.
A meeting was held with the social worker, firstly with him alone then with both of them. The P.R. man thought it was necessary to set up a programme of home help to provide for housework and personal care, while the other rejected this idea and claimed he was perfectly capable of looking after himself.
Periodical meetings with the Self-Sufficient Individual were arranged at the Service, to check the progress of the new situation, with telephone contacts if necessary with the PR man. But it soon became apparent that the arrangement could not be maintained: missed meetings, phone calls to fix another date, other absences and so on in a progressive weakening of the agreement, until the PR man called in alarm: he had received a concerned phone call from the neighbours of the Self-Sufficient Individual.
They reported serious hygienic conditions in the house; in particular an upsetting episode when the Self-Sufficient Individual was away from Rome for a musical event, great lines of ants coming from the balcony of his house, had got into the apartment above. Having obtained no answer, the neighbours called the Fire Brigade who, after getting into the house through a window, were able to explain the problem: the Self-Sufficient Individual had taken up home gardening and had literally transformed his balcony into a dense jungle where the ants had established a community.
We then went to the house. The apartment, dirty and untidy, with corners used to throw all sorts of junk, was not, however, the worst we had seen in the history of the MHC. Let us say it was in borderline conditions for a peaceful coexistence in the sphere of the condominium.

At that point the Self-Sufficient Individual did not object to the provision of home help by a cooperative of home assistance, to be paid for from the money left by his mother through his Legal Guardian, who had been appointed by the judge on the request of his mother.
However, there was a disagreement to overcome between us and the PR Man on how to implement the project. He expected the home-help assistants to carry out a systematic re-education of the Self-Sufficient Individual, to transform him into a perfect householder, by teaching him how to manage domestic matters. This demand, aimed to remodel the Self-Sufficient Individual's lifestyle on the model of that of the PR man,seemed to us to be a risky beginning.
We suggested the Self-Sufficient Individual should participate in a trekking activity group at the Service. He accepted and became an assiduous participant in the activities arranged. Naturally this activity, which he has embraced keenly, does not exempt us from countering the re-emergence of his self-sufficiency, but at certain times, enables us to question ourselves and him about the issue.
With the people present in the scenario described here, I have regular contacts for monitoring, which I consider a necessary measure for maintaining the intervention.
What is the desired product?
To provide the Self-Sufficient Individual with a network that will support him in a state of compatible marginality.

The so-called "serious area" we mentioned earlier, in a sense poses questions to psychological competence. When the Mental Health Centres were founded and the psychologists (numerous in ours and in other Italian regions) entered, sometimes by means of unusual pathways like that of "Psychiatric Animators"[5], many of us, thanks to our previous training, experienced a sort of psychotherapy illusion; i.e. we were convinced that even the most serious psychopathology could be effectively attacked by using psychotherapy. The inevitable disappointment that followed led many to believe that in that area there is little or nothing psychologists can do, since it is the elective sphere of psychiatry (this was in the Mental Health Centres; meanwhile, however, there was a strong presence of psychologists in positions of responsibility at the Day Centres that were gradually being set up); but is this really true?
While psychopathology, beyond a certain threshold of seriousness, proves to be an unsuitable terrain for psychotherapy, it is however true that around psychopathology and the people affected by it, there are a series of problems that can be usefully examined. These problems are inherent to individual-context relationships (family members, neighbours, in luckier cases, workers …), or often to the absence of contexts around people, the lack of contexts of belonging , participation, exchange. And we now know clearly that while on the one hand the state of isolation seems to be a contribution of the intrinsic logic of psychopathology, at the same time it is a strongly aggravating factor. Similarly we know that there is a clear difference if the global intervention unfolds as a reduction or containment of the psychopathology and its manifestations, using the means that prove effective (psycho-medication), or if it

[5] Between 1978 and 1980 the Province of Rome, which at the time ran the Mental Health assistance services, decided to set up "Resocializing clubs" in the Mental Health Centres (as the first local facilities were called, created as a result of the law reforming psychiatric care). These clubs were intended to help the social integration both of the people coming out of psychiatric hospitals as these were gradually closed down and of those who had not been in hospital but who developed psychopathological conditions that put them in danger of being emarginated. For this purpose the figure of the Psychiatric Animator" was invented, and the considerable number of them were taken on with contracts of 'payment for performance'. The Psychiatric Animators were almost all Psychology graduates or students, but included a few other qualifications (social workers, post-grad students specializing in Psychiatry, professional educators…). With the 1980 Health Reform Act, responsibility for Mental Health was shifted to the Regional authorities. The Lazio Region inherited Psychiatric Animators, who were retained in service with renewable contracts up until the passing of the 1985 national law cleaning up casual work. This law recognized the qualifications possessed and enabled these workers to be taken on permanently in the professional roles envisaged by the National Health Service.

envisages the attempt to pose oneself questions on the overall quality of people's life so as to improve it[6].
When one works in a psychotherapy setting, the effective action is carried on in the "here and now" of the operator-client relationship. If things go according to plan, in that sphere there will be non-casual transformations which, thanks to the client's ability to learn from experience, will have reflections in the "there and then" of his life, where the difficulty that led him to the psychotherapist originally began.
When one works in the "serious area" this operative paradigm no longer holds, and it becomes necessary to actively intervene in the "there and then".
By saying this we are not saying anything new, seeing that this is what has been done for many years. I think, however, that what might appear to be the same action may, on closer examination, prove not to be the same. In the over 25-year history of local mental health assistance, the attention and intervention in real contexts have at times seemed mechanical as if the problem were solely that of finding material resources or as if it were possible to achieve levels of person-context integration "by decree", as it were. Other times we have seen people taking what looks like an illusory short-cut: creating contexts in which to eliminate the differences between patients and operators as if that were enough to make the former as capable of coping with the world as the latter.
But while the psychotherapy setting is not a usable tool, as we have said, the same cannot be said for psychotherapy and clinical psychology knowledge and what they entail in terms of possibilities for non-conventional readings of relationships and contexts , and for support and orientation in non-stereotyped action.
I therefore think that the venture one can work on today is to unite the capacity for action in real contexts - with special attention to the symbolic dimension - with the psychological depth of relationships, and with the capacity to capture the peculiarities of people (as well as psychopathology there is also a psychology of subjects) and of contexts[7].

The Ascetic
At the age of forty-seven, the Ascetic lives with his parents. He is a diagnosed schizophrenic and has a long psychiatric record marked by many attempts at treatment in different contexts. I met him when I went to his home with a psychiatrist colleague, after he had explicitly broken his connection with the Service, his treatment, and in a sense, with the world outside his family unit.
His parents informed us of his refusal to have treatment; his refusal to leave the house for any reason; his constant musing, and in part, his raving on religious and mystical matters; the irregularity of his sleeping-waking and eating patterns; the constant compulsive hand-washing.
On meeting them what one noticed most was the father's irritation and annoyance at the son's ideas; feelings that translated into blaming and reproaching.
For his part the Ascetic complained of his father's intolerance and lack of respect for his intellectual interests, giving only glimpses of raving, and through a stubborn silence, refusing to explain the reasons behind his behaviour, in particular his refusal to leave the house. He confirmed his rejection of the treatment but said he might return to the Centre to talk.
During one of the later encounters, while the parents were not present, and after a long silence, the Ascetic said "I am the Secretary of Jahvè; I am founding a new religion to fight Satan!" This was uttered in a tone of dreadful revelation, as if to say: "You insist on wanting to know what is inside my head, and I will tell you, but you will be frightened by it!".
In fact, I was struck by that flash that seemed to illuminate the outlines of something hitherto obscure; but he himself must have been frightened because he immediately added: "But perhaps… for these things a doctor is needed". So it was that he recommenced treatment.

Since then the internal family situation has changed; the Ascetic's obstinate seclusion, however, has not.

[6] In this respect, see considerations about concepts of "recovery" and "outcome", written by Ron Coleman (1999) in the work *Recovery, an alien concept*.

[7] Some experiences, in this perspective are discussed in Scala, De Toma, Tulli, & Bacigalupi, 2006. See references below.

The medication is taken by him, but the effect goes far beyond his person. One could say that it is the family triad that takes the medication.
The treatment creates a barrier against the raving; the Ascetic still cultivates it but in a relatively separate part of his thoughts, while the family relationships are free of it. This different arrangement has changed his image in the father's eyes: he no longer sees a son lost in absurd, obscure daydreams that he confuses with reality, generating in him an impotent rage; now he sees a shy, fragile, lazy son, frightened by the world; a son who needs to be protected and given what he will need for the time when the parents will no longer be there.
Consequently, the request made of the Service has changed, too. At this point the parents seem to be saying: "Let him be, now the situation if fine, help us to keep it so and show us that you remember we are here".
The Ascetic continues, tenaciously, in his seclusion in the house, the need and meaning of which he does not explain. He knows that sooner or later he will have to face the world outside, but for him, busy with far more essential questions, there is no point in worrying about the future; he will think about that when it can no longer be avoided, and, for now, it can; all necessary contacts with the outside world are taken care of by the parents, with kindness and tact.
Life goes on, apparently as unchanging as clockwork.

Another observation arising from current experience in the mental health services is how often a situation that appears pathological and inadmissible may represent perhaps the only possible equilibrium for a given context at a given time. And one arrives at the paradox of seeing the mental health workers being 'more realistic than the king' in offering to repair something that nobody has asked to change.
We are far from knowing everything about the schizophrenic existence and the relational systems it involves. It therefore seems that the most appropriate way of facing this reality is an attitude of respectful curiosity, oriented to understanding little by little what it is useful or possible to do, knowing that, at times, the only function that can be usefully carried out is that of maintaining equilibriums that we have not chosen ourselves, that nobody has chosen, since they are the inevitable outcomes of determining factors that we do not have access to.
The impression one gets from working with this type of situation is that very often small, but appropriate, inputs are far more useful than a great deployment of energies presumably badly channelled, and that constantly maintaining a non-invasive presence allows space for credibility and for intervention when, due to inevitable changes in living conditions, the usual balance is lost, as when people in the position of the Ascetic lose the support of their parents.
There are more questions and points for reflection and research, perhaps, than answers; but at the moment this is what the state of things allows.
I hope that the picture outlined is clear enough to show that, despite the viewpoint of mental health decision-makers – tending to be unspoken, but systematically acted out - (over the years we have seen the progressive reduction in the number of social workers and psychologists, while the number of psychiatrists and nurses has remained the same or increased), in the operative context of the Mental Health Centres, psychological competence could make interesting contributions in various directions.
But are the psychologists – those in the services and those who might enter – aware of this?

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