

Report 3 – Practical training in health facilities and at Mental Health Centers

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In this paper we will discuss some issues we encountered in our practical training experience at the Reception Service at the Mental Health Center of the local health area in Rome, 'ASL Roma D'. We will start with the way we dealt with some demands addressed to the service, and then reconsider some aspects of the organisational functioning of the service itself.

The Reception service at the Roma D Mental Health Center is unusual in that it is organised around a maximum of 8 clinical psychology interviews. Assistance organised in this way does not serve as a system for filtering towards other specialists, but establishes a clinical organisational service: through interventions limited to 8 interviews, the Mental Health Center wants to be considered with its own particular limit.

A parallel can be drawn between the trainee's experience in a Mental Health Center and the patient's experience at the Reception service: having time limits on their experience, they can both find that time, in its sense of limitation, becomes a resource from which to consider the problem, or the opportunity to expand the dual dimension implicit in the psychotherapy relationship, in the context.

It is not only the trainee and the patient, therefore, but also the context of the Mental Health Center and the related social system that need to become central for the intervention to be successful, in the attempt to connect symptoms and social systems and to explore avenues of development.

The case we will present exemplifies how resources can be activated in a perspective of development, using the *limit* as the criterion organising the way a demand is treated.

In particular, we will present a case that gives the opportunity to think about how it can be assumed and symbolised: about the risk that the limit may take on a sense of value or duty instead of the possibility that it is a resource serving to construct a separation, or, to use the patient's words, "the capacity to think of one's own solitude".

In summer, F., a young man of 30, comes to the reception service, referred by a GP, for a state of depression that he fears may make him fall back into his previous bulimic behavior. He reports that a long love relationship has ended and he cannot manage the separation due to the sense of emptiness that it has left him.

Three factors seem to be organising the request for consultation: a medical referral that conveys to the patient the expectation of a cure, a disorder like bulimia that threatens his physical and mental health, and a separation that leaves a gap that needs to be filled.

What the organising factors share is the passive attitude in which the patient finds himself: he has been referred by the doctor, he is affected by bulimia, he has been abandoned. This passivity, acted out in the therapeutic relationship through the expectation of a solution, reveals the patient's way of relating to his own emotions as facts to be controlled: by closing his emotions into pacifying rationalisations or in bouts of overeating, the patient is able to maintain his image, which otherwise would be threatened.

It is again passivity that organizes the relationship with the psychologist: the patient is compliant in ending the relationship regardless of the goals established or still being established. This compliancy makes it difficult for the patient to start following his own life plan.

The first series of interviews ends without an explicit exploration of the values with which the patient and the psychologist deal with the separation, that is, by not acknowledging the complaint position and the patient's experience of abandonment in accepting the end of the intervention.

It is when F. returns in autumn, again referred by his G.P., that it is possible to work on these aspects. Now, the separation experienced in the first consultation becomes the chance for F. to interpret feeling abandoned as a difficulty in abandoning himself to the complexity and unpredictability of emotions and also as a chance to reconsider his own image, constructed in relation to what is known and what has been known.

Connecting the new request for consultation to the desire not to be abandoned enables the patient to recognise his own demand and above all to recognise his own involvement in wanting to deal with it.

This is an active position, a choice, outside the logic of the relationship organised on who takes care and who is taken care of, to construct different possible meanings of his experience.

The transformational goal of this therapeutic relationship involves understanding separation as the competence to think of one's own solitude.

It is significant that at the end of the interviews F. no longer experiences the separation as an emptiness to be filled by gorging, but he sees it in relation to a life to be filled with meaning by new things such as the desire to look after a dog and to actively commit himself to a work project he has long wanted to do.

Handling F.'s demand meant recognising, in the time limit, the establishment of the intervention time, in which the fundamental role of the psychotherapeutic relationship becomes that of thinking what development plan will mark the separation.

In particular, handling F.'s demand meant rethinking the constraints of the service on the work carried out with the patient in the service.

In other words, rethinking the constraint of 8 consultations enabled us to give the patient the chance for a second series of consultations, that is, to leave the door open to a fresh availability: the limited resources of the service, dealt with in their emotional symbolisation, allowed an intervention that could be oriented according to the patient's 'elaboration time'. Allowing him the chance to go back and experience a space, a time, a relationship, in which he could explore his fears, his obsessions about desires and plans, enabled the patient to see the separation as a choice, a desire to test himself, to get involved in achieving the life he wished for.

It is precisely the development of the patient, from within the culture of the Mental Health Center, that constituted the specificity of our practical training experience .

The patient, or the external client, helped us to look at the internal client, to think of the functioning of the service as a clinical-organisational provision established in a temporal dimension by the Mental Health Center, which as such is a regulator of relations.

It is therefore a clinical-organisational provision that does not aim at solutions of long or short, terminable or interminable psychotherapies, but that, using the limit, sets out to trigger processes, to get resources moving, to involve individuals to shoulder the burden of their own demand in a perspective of development.