An intervention in a Mental Health Centre

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Preface

We will present the report of an intervention carried out for a Mental Health Centre (CSM), in an Italian town of more than one million inhabitants. Some comments on the development of the Mental Health Services in Italy, in the last thirty years, will precede the report of the case. The same clinical psychology categories used in analyses of organizational relationships, adopted to outline this process, will be later used to present the report on the intervention in the CSM

These introductory remarks on the Mental Health Services development will be useful for those who are unfamiliar with the specific Italian situation. In more general terms, however, we think it is always useful to sum up the characteristics of the context in which the psychologist intervenes. In fact, we adopt an approach to the intervention that involves a profound knowledge of the context where the intervention is realized by bringing together methodology and context, in a close connection.

We will explain what a report is, in our view, and why the intervention in the CSM is an intervention of clinical psychology. In our opinion, every intervention that uses as its tool the relationship between the psychologist and his client, is a clinical psychology intervention. As for the report, for the clinical psychologist, reporting constantly about what happens during his work is the best way to manage and assess the intervention itself. The report, useful both to the work-staff and to the client, is written starting from the reading of a client's demand, and proceeding towards the project, its realization and appraisal. We will put forward here, with the report of the intervention in the CSM in a context of scientific debate, the last draft of the report we used to carry out the intervention and its evaluation. It will be possible to see that while the relationship between the psychologist and his client is being reported, it is also being constructed, with the use of clinical psychology categories.

As it is a report written after the conclusion of the intervention, today we will use it above all in its role of appraisal.

Development and prospects of the Mental Health Departments

The founding principles of the Mental Health Departments (DSMs)

A new approach to metal illness was promoted by legislation starting with Act n.180 of 1978[1]. The main aims of public service were modified: from social control of psychiatric patients they shifted to the promotion of health and the prevention of psychiatric disorders. In the meanwhile, a reorganization of the relief institutions was set in motion by the legislator. Primary importance was given to intervention by the Services in local areas, rather than to those based on hospitalization, as it was before. Each territorial health service (ASL) must institute the Mental Health Department DMS).

The DSM is formed of different structures: a territorial structure, the Mental Health Centre (CSM), the organizational centre of the Department; a psychiatric service for diagnosis and treatment (SPDC) within general hospitals; some intermediate structures for semi residential activities

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[1] Act n. 180 of 1978, later summarized by Act n.833 of 1978, the first step of a legislative process that later - and for some too late – specified its contents. The interested reader can see the DPR 7/4/1994, project-objective "Mental Health Care 1994-1996" and the DPR 10/11/1997 project-objective "Mental Health Care 1998-2000". We must also remember that health care is regulated by regional laws, that differentiate the organizational set-up of mental health care structures throughout the national territory.

(daytime centre and/or day hospital) and some facilities for residential activities (i.e. therapeutic – rehabilitation communities, social – rehabilitation communities, lodging communities). The departmental model of organization was thought able to promote unified planning and the management of activities aimed at mental health care, in its preventive, curative and rehabilitative measures.

Let us look to the Mental Health Centre, the facility where the intervention reported here was carried out. The present legislation[2] gives the CSM wide scope for intervention in its local area, and gives it the role of coordination. The CSM identifies social resources and integrates them to realize personalized interventions. It should be remembered that the DSM social mission[3], also supported by repeated WHO recommendations[4], is characterized by two priorities: the exploration of what people ask for and interventions based on agreement. Consequently the function of the mental health centre in the DSM is achieved when it is oriented to the problems faced by people, groups, and contexts. The law prescribes these aims, while the different DSMs should translate them into goals. But as we will see, the aims of the law are hard to translate into coherent intervention by the services.

Thirty years of history

We will now suggest a re-reading of about thirty years of CSM history. As our main criteria we will use the evolution of the social mission, of the relationship between the services and their users, and of health intervention. In the meanwhile, we will look more closely at the major critical points now existing in the defence of mental health.

The Mental Health Departments (DSMs) came into being due to the idea of the social-health treatment of mental disease. They are very different from the other Health Services. The DSMs immediately appeared to be an unusual type of organization, an interesting new challenge. For this reason, their organizational structure could not be supported by the collusive set-up[5] typical of hospital organizations.

In the last twenty years they have undergone an original evolution. Below we show the various models orienting their way of working. Their sequence is not linear; in fact, they are cultural dimensions, whose relative predominance changes as time passes, but whose presence does not cancel each other out.

Ideological period. As soon as they were instituted, DSMs were proposed by the laws and started up, on the whole national territory, as organizational structures alternative to the hospital service.

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[2] DPR 10/11/1997: project-objective "Mental Health Care 1998-2000".

[3] In this paper we refer to specific models dealing with the organizational relationship; they come from a more general theory of collusion as a clinical psychology theory of social relationships. By 'social mission' we mean the legitimating of professional activities, deriving from shared values within the community where the professional works. By '*commission*' we mean the integration between the social mission and the client demand, oriented by the general aims of the social mandate and translated into goals, shared with the client.

[4] The trends of Italian law agree with the international lines. Since the nineties, the WHO has more than once expressed itself about mental health. In particularly after the famous epidemiological work promoted by the World Bank that stresses Mental Health as a priority for the 21st century. (Desjarlais, R., Eisenberg, L., Good, B., & Kleinmann, A. (1995). *World Mental Health: Problems and Priorities in Low-Income Countries*. New York–Oxford: Oxford University Press (trad it. La Salute Mentale nel Mondo, Bologna, Il Mulino, 1998). In this work WHO points out five organizational principles to promote service efficacy. We simply list them, and refer the reader to the publication for their clearer definition. Services must be: decentralized to assure proximity to the demand and continuance to the intervention; versatile, that is problems culturally integrated, cheap, and able to enhance resources.

[5] Authors refer to clinical psychology intervention, both of the social relationship and of the psychological intervention, where the construct of "collusion" is central. Collusion indicates shared emotional symbolization of a context. The collusion theory and the analysis of the demand methodology are discussed in many papers and books. We refer the reader, for a recent sum of this model to: Carli R., & Paniccia R. M. (2005). *Medical cases: reporting according to the clinical psychology*. Bologna: Il Mulino.

Those present above all were nurses, physicians, a few social workers and some psychologists[6]. The prevailing culture is militant and aimed at deinstitutionalization. One of the aspects characterizing the militant attitude is the non-differentiation of working roles. In this period the concept of "social worker" emerged. The social worker shared a common ideology of freedom with the users. The receiver of the service is the society. The struggle against institutionalization became an event having value 'per se', and it had a therapeutic effect: the method corresponded to the outcome. But the prevailing impression of access to services is that of compulsoriness, like in the mental hospital. The new ideological services and the psychiatric system share the same assumption of the removal of the variability of the subject and his demand, albeit from opposing points of view. During this first period the DSMs are the same as the CSM (Mental Health Centre). When they receive a demand from their patients, above all they perform out-patient treatment or a house-to-house service.

They also carry out interventions in the social context, putting territorial resources, from parish churches to organized social activities, into motion. The patient becomes, in this period, an object of salvation and oblation; the militant does well, by definition. It is useful to remember that sacrifice, as a value *per se*, does not know the meaning of 'evaluation of work carried out'. There is no product, nor shared outcome.

The organizational function vanishes, and the demand is fixed (set), coming from an inheritance of mental hospital. The culture of being snowed under with work is fed; there is an atmosphere of sacrifice and voluntariness. These services' roots in the local area, their proximity to the users' residence, the visibility of their use, often made them barely approachable: the atmosphere was marked with stigma, more than today.

The new social mission, characterized by de-institutionalization, did not automatically change the way mental health services are viewed emotionally. This feeling made them as inescapable as they were undesirable, in spite of their ideology of liberation. In spite of the ineluctability of the operators-user relationship, it was however possible to develop innovative interventions, designed for new needs or previously unexpressed needs. This all made the Italian experience an interesting workshop for many other countries.

Technical period[7]. In the following ten years there was the evolution from the "set" patient to the "guaranteed" patient. The relationship between the services and their users changed. The "set" patient, typical of the psychiatric culture, reached the first DSMs straight from the mental hospital. His demand was not considered, and reference was made to a social mission concerning the gravity of the case and the need for a restrictive context for his presence. The guaranteed patient belongs to a new culture, that of the specialist public health service. A strong expert and weak layman meet in a relationship that collusively reinforces this dependency. During this second period, the number of physicians increased, the social assistant became an important resource, but above all psychologists number was up. Theories of mind actively took hold and psychotherapies started having their schools. From the eighties to the nineties, while the

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[6] Carli, R., Guerra, G., Lancia, F., & Paniccia, R.M. (1984). Psychosocial intervention in the mental Health Service: an experience. *Rivista di Psicologia Clinica*, 1, 75 - 95.

[7] Once again we propose a model of organizational relationship based on the collusion theory. The relationship we describe as 'technical' is that of strong expert and a weak layman. The dependence of the latter on the former is at the same time reversible, limited and characterized by a marked asymmetry: all the knowledge organizing the intervention is held by the expert.

The layman is only asked to trust the expert's know-how. The model of a medical relationship is a good example of what we are talking about. The technical model characterizes more than any other the health organization. And it hinders both the development of an organizational expertise, and the correlated client orientation in the Health Service.

At the beginning of this paper we emphasized the innovative character of the mental health departments within the health service and pointed out the attempt to treat a problem like mental health, which is not easy to reconcile with the parameters of illness, in a more suitable environment than the purely medical. How this intent will be achieved is in the background of this analysis. The approach to the client in the terms we suggested, is also a model of a collusive relationship. In it, there is a relationship between a weak expert and a strong layman. Technical expertise is placed at the service of the layman's strong demand and of his serious problem within a relationship aimed at knowing the other and not at his emotional control.

community psychiatric was developing, the technical culture refers above all to the psychotherapies. In the organization of the services, the technical aspect was expressed in the development of a reception function designed to provide the patient with a whole set of technical services. The technical services become fundamental also for the definition and the differentiation of organizational roles, which are confused with the professions.

The technical approach moved the services towards a self-referential practice, supplying them with a filter designed to accept what the different techniques made it possible to handle. The population of specialized physicians, psychologists and psychotherapists that was set up had difficulty assuring integration within the services, constructing lines of intervention that take resources, tools and goals into consideration. In other words, a population of specialists was set up, who were not familiar with the organization and its way of working. All this has significant consequences for the evaluation. Each technique had its expected results, foreseen by its procedure. The outcome of people with professional expertise, organized within a strategic framework in roles and functions to offer a service to a client[8] was a different matter. Here the service to the client and its evaluation were more important than the results of the techniques.The technical culture unfamiliar with the organization led to great investment in treatment outcome evaluation, with the consequence importance of quantitative data collection. Psychopharmacological research was increased, and the use of new drugs promoted, according to an increasing necessity to monitor the technical quality of services and of their outcomes. The different theoretical biogenetic, psychogenetic and sociogenetic approaches to mental disease met in the services, through the juxtaposition of professionals who were deeply rooted in the schools they belonged to. DSMs still seemed not highly articulated from the organizational viewpoint and in search of integrative models, while the internal structures were increasing. It was not easy to find models of integration if the focus was on the outcomes of conflicting techniques, and there was at the same time a lack of attention to the client and to the evaluation of the service.

The Mental Health Services (CSM) took on a form as places of the summation of techniques, due to both the psychological and medical component, mainly trained at psychotherapeutic schools (analytic, relational, cognitive). It was due precisely to this situation that the CSMs became the strongest developmental factors of the new psychotherapeutic models. Psychoanalysts, cognitive and relational psychotherapists, continued to debate and discuss within the mental health services of big cities. The main aspect of these exchanges of views was, on the one hand, the strengthening of the irreducibility of the single theoretical models; on the other hand, the challenging of these models and the emergence of a surprising similarity between their practices. This was true above all of the cases of so-called serious patients, challenging and showing the limits of the models themselves. It is no coincidence that they confined their clashes to this arena; handling the more general problems of the Services and a different demand from that of the serious patients would call for other kinds of competences.

The Current period. The present is characterized by great complexity, marked by a greater multiplicity of procedures than in the recent past. Administrators, staff and users seem to be able to identify the current problems and needs, as well as the inadequacy the services have shown year after year. However, while interesting local activities thrive, there is an evident, widespread inability to translate the new awareness into practice. Whereas the cultures permeated with ideologies and technical know-how are no longer confused, the new ability to read problems is not yet linked to sufficient expertise in finding suitable tools and methods.

Some difficulties become understandable if we consider that the social mission on mental health was entrusted to the medical context. Within this context, a the client-oriented model of intervention collides with the medical model, based on the medical expertise. Psychiatry can be considered the place producing the critical events[9] that draw attention to resources, but also the drawbacks of

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[8] What we call 'client' it is also e model of collusive relationship. A relationship where a weak expert gives his service to a layman strong in his problem, and where he designs the intervention for the development of the layman rather than to compensate his own weakness.

[9] By 'critical event', we mean the organizational dysfunction that occurs repeatedly and which cannot be modified. It's proposed to read such events as a failure of the collusive models that on the one hand support the relationship in an organization, on the other hand are a resource to identify the characteristics of the working of organizations and possible developments.

transforming the most problematic areas of our living together in society, into health problems. For psychiatry, in fact, it is difficult to "separate" the illness from the patients, as usually happens in medicine. Furthermore, the weakness in knowledge and methods doesn't allow an intervention based on the technical strength, as in other health disciplines. This has seemed even clearer in the last decade, with the spread of evidence based medicine into psychiatry, aimed at encouraging the adoption of measurable and comparable procedures.

One more consideration, about "localization", which was a fundamental principle of the mental health reform and *raison d'être* of the CSMs themselves. From the administrative perspective, localization reflected the principle of accessibility, in other words the equity of resource allocation promised by the universalistic Italian health services. However, the result is a limitation in the users' choice of service, which nowadays is less and less acceptable. While making this comment, we also are thinking of the other component of "localization".

"Localization" is intended to connect the way the services work with knowledge of the users' demand.

The way the services interact with the demand shapes the demand itself, and psychiatry today is characterized by a lot of problems related to the *commission* constructing.Below we point out some problems characterizing current psychiatric services, useful to the case presented here. They are some areas of intervention that could be developed, that call for the acquisition of a more mature professionalism combining clinical expertise with the organizational skills.

The shift to enterprise. All health services, according to Law 833/1978, were grouped into managerial and administrative Units, called Local Health Units (USL). Later legislative decree n.502 of 1992, started the process of shifting to enterprise, founding the local health enterprise (ASL). This process, in which the legislator was to intervene many times, can be considered still in progress. These interventions took place in a domain that tends to ignore its own organizational aspects. In other words, it is underlined that the health service structures too constitute an organization, or a set of systems using scarce resources (human, technological, of knowledge, economic resources) to achieve goals with their clients. The enterprise process stressed the economic importance of the acts performed by the health service. This process introduced, in the practical working of the health services, the aspects both of the limits and the cheapness of the health intervention[10].

It should also be pointed out that the organizational models of the DSMs created in the different regions of Italy are different from each other. The organizational models for the DSMs have to be conceived in terms of the logic of business rationalization and at the same time reflect local diversities[11].

The internal reorganization of the Services. There was the spread of a project management approach, which does not correspond merely to a summation of techniques, but is client-oriented. Concerning the anchorage of the service staff to their professional identity, rather than to roles and functions, a phase of reflection opened, with particular attention to functions (i.e. welcoming, case management).

The redefinition of the seriously ill patient. At first the patient was called 'seriously ill' as regards the psychopathology affecting him/her (schizophrenic disorders, serious mood disorders, personality disorder), while nowadays, more practically one deals with "serious cases and/or non compliance". This redefinition focuses on the context/service as a system and requires a new conceptualization

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[10] See Carli, R. (1998) Health and Enterprise: reflections on the health organization. *Prospettive psicoanalitiche nel lavoro istituzionale*, 16, 3, 326-347. the work is about what the author defines, with regard to the medical culture, the efficacy paradox. The initiatives of cost control are in continuous conflict in this domain. The author compares efficacy as goal realization and efficiency as resource optimization to the realization of goals, in the health context. By stressing that the health aim is to improve the population's health, he underlines that this aim has no limits, and that it consequently allows the risk of a paradoxal efficiency, with unlimited resources. Poor resources are adequate only for definite and limited goals, with regards to client and context.

[11] See, for instance, the interesting proposal in Thornicrof, G., & Tansella, M. (2000). Handbook for the mental health service reform. Rome: Il Pensiero Scientifico.

of the intervention itself. Hence, also, the interest in models of intervention with a strong Anglo-Saxon matrix, like ACT (Assertive Community Treatment)[12].

The demands coming from other organizations can be considered developmental areas of the services because they involve, more competently, environmental variability[13]. Think, for instance, of the family associations and more recently of the users. These associations are a strong client for the services. Voluntary and no profit organizations are beginning to interact with the working of the services, most often by participating in the realization and the management of intermediate services.

The demand related to the so-called common mental disorders (Goldberg, D., & Huxley, P., 1992)[14].

This is a type of demand that is not quickly organized in the modality of demand for care previously made of the services. It often has other agencies as the referent; for instance it may involve a relationship with the family doctor. It is a phenomena with an important social and health impact, which clearly emerged from both statistical and epidemiological findings on the numbers of people using CSMs: half the demands are related to this area, with slight variations. Like the previous demand, it shows how in the mental health services, there is nowadays a demand from users who cannot be considered, or taken for granted, as patients, or conceived in a treatment process. These areas arouse criticism of the working of the context and its protagonists, and lay stress on the importance of planning criteria and on the realization of intervention projects, discussed and assessed in a client-oriented approach.

Reception. One of the most important issues in the services seems to be connected to the delivery of technical outcomes inadequate for the solving of problems adduced by the client.

The technical model (whether medical, or nursing, or psychological) works by choosing the object where its technique can be applied, in other words it needs a self-oriented filter. The challenge of the demand-oriented services is that the filter does not eliminate what the staff are not expert in, but meets and classifies the variety of demands.

The therapeutic project and the process of shouldering the burden. The CSM has, in the Department, a central position because it is the place where the demand arrives. To reach the other structures (apart from the hospital, for instance the SPDC, that can be reached directly by patients in emergencies) it's necessary to go through the CSM. Its functions are, as mentioned above, to assure, to build, to work for integrated therapeutic projects. The importance of this integration, for a respectful shouldering of the burden of the patients and their relatives' and o the wider context's demand for quality of life, is today in the public eye more for its failures than for the outcomes obtained. Requests for training and interesting reflections are still motivated by difficulties in the relationship between teams and services, and within the services themselves[15].

An intervention in a CSM (Mental Health Centre)

The analysis of the demand

Let us start from who asks what, to whom. The CSM, through the training director, contacts a group of psychologists, from now on, called GP. The GP provides the organizations with clinical psychology consultation. One of the psychologists meets the training director, in the GP's office. The director of the CSM

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[12] Burns, T., & Firn, M. (2002). *Assertive Outreach in Mental Health: A Manual for Practitioners*. Oxford: Oxford University Press.

[13] We call self referred organizations, those who represent their client as an enemy, who bothers the stability of the technical core of the organization, with the variability of his demands and problems. The core is protected, at the boundary of the organization, by a filter that makes it impossible for the client to approach the technical core (i.e. through bureaucratic procedures). Besides client-oriented organizations are those who organize expertise and structures to get in touch with the client, to know his demand. In this last case, the variability of the client is a source of information and not a disturbance.

[14] Goldberg, D., & Huxley, P. (1992). *Common mental disorders: A bio-social model*. London - New York: Tavistock/Routledge (trad. it. *Disturbi emotivi comuni*, Il Pensiero Scientifico, Roma, 1993).

[15] We remember the intense exchanges of training carried out between the services; we refer the reader to the publications on the theme, for example: Correale, A. (1991). *The institutional field*. Roma: Borla; Refolo, G. (2001). *Next psychiatry*. Torino: Bollati Boringhieri

says that the CSM is deciding about its training through some assemblies among its staff, defining both their training demands and the teachers they would prefer to have. Two matters are stressed by the training director of the CSM: on the one hand the CSM asks for supervision for the serious cases (a "clinician" who has trained some of them in psychotherapy, has been contacted for this); on the other hand the CSM is also interested in an intervention on its working group dynamics, considered as a problem. The training director, on the one hand, speaks about the recent constitution of some interdisciplinary groups, for example the group working at a half-way house; on the other hand, he speaks in general of the group, to mean the whole staff of the CSM. It is for this second activity, an intervention on the CSM group dynamics, that the training director applies to the GP. Some employees of the CSM, in fact, know GP as an expert group in communication and conflicts. The training director adds that not all the employees will take part in the training, because some of them do not agree that the conflicts among them are a real problem.

Moreover, also among those who think it's a real problem, there is not complete agreement: some of them, in fact, are not interested in consulting with someone on such a question. Some employees, in fact, believe that the difficulties in working together must be solved among themselves, without the presence of a stranger, and that it is only the responsibility of the CSM staff to solve their problems.

The training director also gives some information about the history of the CSM. In particular, he tells why, according to him, the employees are in such a problematic relationship among themselves. To a long-established group of "old" staff members, many new entries, physicians above all, have been added. In the past they lived happily together. There were conflicts only with some head physicians, judged incompetent. The training director recalls, with a certain pleasure for the strength shown by the staff, when a harsh conflict caused the early retirement of the top clinician. The recent entries, especially the psychiatrists with a more organicist approaches than those of the Old Guard, characterized by a common psychoanalytic orientation, destabilized the cohesion of the staff and created tension. In the training director's speech, there is the hope that, at the end of the intervention, the same cohesion of the past will return. The training director ends his request by specifying that what he said was his own opinion. He was speaking for himself. To understand what his colleagues want, GP will have to speak directly to them. As far their presence, each of them, will chose, in a personal capacity, whether to take part or not, at only one or both the training meetings. Two psychologists of GP, after this first conversation, go to the CSM to discuss the training director's proposals with the division head of the CSM. At the meeting the training director is also present, and he meets GP just before the top clinician arrives. On this occasion the training director starts an interlocutory conversation with GP, and as if he were talking about something unrelated to the demand for consultation, comments that the top clinician of the CSM is really afraid of the Association of patients' families. As soon as the top clinician, a psychiatrist in his first experience of leading a service, arrives he says that he has nothing more to add to what has already been said by the training director.

The top clinician seems to be desirous both of satisfying the requests of his colleagues and of receiving the advice of GP, whom he asks for a project and an estimate. The budget available is equivalent to fifteen GP working days.

We now have a lot of information about the demand by the CSM. Let's start with who submits the demand. What kind of organization is it? From the two previous meetings we can gather some symptomatic elements of the collusive demand of the CSM. The training director proposes many considerations in a private capacity. He does not seem to have assumed the function specific to his role, of guaranteeing a synthesis of the formative needs of the CSM and of formulating an adequate demand to the consultant. Rather he seems to be the spokesman for the requests made by some of them. Within the CSM, not only the discussion on their needs, but also the decision on the training activities is taken at an general assembly. Differences of opinion and conflicts emerge. No difference in roles and functions seems to exist. There seems to be a lack of hierarchy to mediate conflicts on the one hand, and ascribe specific responsibilities to the different organizational roles, on the other hand. Rather, the CSM is characterized by a long-standing rejection of hierarchical roles, shown by the repeated conflicts between employees and directors. These conflicts, in which the directors opposed by a compact group of employees, have allowed the latter group to develop a shared feeling of belonging to the CSM. It was a form of belonging based on the expulsion of differences from the group, through conflict with the 'diversity' symbolized as *enemy*. The CSM proposes a modality of belonging that doesn't discriminate, and which is not suited to identifying and integrating the different expertises necessary to the organization. Hence the weakness or the lack of roles and functions. As far the present top clinician is concerned, he seems afraid of his role. As regards taking on the demand, he escapes it and complies with the various needs that come up with reference to training, rather than starting from them to look for a strategy to intervene in the problems of the CSM. As a consequence the different needs produce two training initiatives, seen by the top clinician as being in competition: the supervision of serious cases on the one hand, consultancy on the working relationship among employees, on the other hand.

Between the two training initiatives there is a not interpreted relationship.

We add that when the top clinician of the CSM and the training director talk about the CSM, they make no mention of roles and functions. Instead, they talk about professionals: physicians first of all, and then psychologists, social workers, etc.

A first hypothesis is that the two kinds of training express the split between the professional practice towards the client (intervention on the serious cases) and the wider organizational functioning, or the context in which such practice happens (conflicts in the working relationship among employees).

Well-known difficulties come to mind, related to the organization of the health context; these difficulties derive from the power of the prevailing medical model, that makes the whole organization rotate round the physician-patient relationship, making any integration difficult, either vertical or horizontal[16].

Moreover, professional practice is recognized as an expertise (supervision), whereas the organizational relationships are reduced to conflict in the relationship between people without a role (request of an intervention to correct some generically tense relationships, through a generic "dynamic of the working group"). Finally, it should be noted that in the request for GP consultation, no reference is made to the relationship between the CSM and its client. The problems within the CSM seem to exist apart from the relationship with this fundamental interlocutor of the CSM whereas the presence of a conflict with the Families' Association is only remarked casually in passing.

In summary, we seem to be dealing with a self-referential culture, lacking in an organizational modality that defines, connects and integrates the different expertises.

The split appears between technical expertise (that they want to strengthen by the serious case supervision) and an ignored organizational expertise. Instead of managerial expertise, where the relationships are organized by roles and functions, there emerges the representation of the CSM as a place populated by people characterized by a profession (physicians, psychologists, nurses, social workers) and by idiosyncratic traits, such as personal story and character. On the whole, the CSM looks to be on the point of breaking up. The break-up is opposed by a centripetal movement marked by the defensive cohesion of the group against any 'strangeness'. For instance, the defence against 'strangeness' represented both by the hierarchy and by professional expertise, which are different from one's own (pharmacotherapy against psychotherapy, and vice versa, but also psychologists against physicians, and vice versa, and so on). But there is also a defence against 'strangeness' represented both by the consultant (our problems have to be solved amongst ourselves), and by the management of the Department.

Let us see now to whom the demand is made, and what they are asked to do. One might think of experts in conflict resolution and communication who have to lead the group back to its lost cohesion. It is a generic "group" that in itself sums up and blends all the organizational relationships, and that currently presents some dysfunctions, which can be interpreted as deficits to rectify, or as information that the CSM can acquire on its way of working. Some information, for instance, on the object it pursues, on the relationship with its customer, on the relationship among the employees themselves. Communication is represented as an expertise split from the context, a source of conflict where people who carry it out have a deficit in the knowledge of its basic techniques. This is in correspondence with a quite consolidated tradition, in the field of organizational training. In this kind of "package" training, that always repeats itself according to the same modalities independently of the contest in which it is provided, communication is treated as an expertise without any link to the context where the communication takes place. And one thinks it can be learnt by referring to a good-communication model, with adequate training for whoever is interested, by the consultant. As far the conflicts, they can also be separated from the context and from the comprehension of their causes, and they can be seen as dysfunctions to correct. It must be noticed, moreover, that in the demand of the CSM, a specific way to define the problems is present: the training director, didn't only talk about the

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[16] Concerning the conflict that can develop between the relational model typical of the physician-patient relationship and the organizational management, we recall a consultation carried out in a SPDC, a psychiatric ward of an hospital. In this case, too, a consultation was asked for because of the conflicting communication characterizing the SPDC staff. It was clear that the psychiatrists held the leadership of the service, but they couldn't translate it into an effective coordination of the activities. Instead everybody was in competition with everybody else, and the psychiatrists in particular were in competition amongst themselves. This happened because of "medical responsibility", which prevents them from entrusting the care of their own patient to others. Thus there was the following problem: in the service there were both physicians who favoured a hard pharmacological treatment (metaphorically called "intravenous" physicians), and physicians who preferred a lighter one (called oral "physicians"). Whenever an "intravenous" physician took over the shift from an "oral" physician, the nurses changed the in-patient therapy. And vice versa. Thus, the same in-patient could be treated with subsequent, different therapeutic modalities, according to the physician responsible of the treatment at that moment. The integrative measure implemented at the end of the consultation was to place the intravenous physicians in Emergency, the "orals" in the ward. Guerra, G., & Paniccia, R. M. (1987). To analyze the demand: an intervention in a SPDC, *Rivista di Psicologia Clinica, 1*, 54-64.

group dynamic, to point to the locus of the problem, but he also supposed that the solution could be to do some "group dynamics" in the presence of the consultant. Words like "group dynamic" recall a specific culture, where people working together are thought to share emotions. According to this approach, it is possible, through a group discussion that allows the expression of these emotions, to promote learning about them. This is without necessarily involving at the same time, the context where they work and its analysis.

In brief, in this demand there could be the hypothesis that people working together in the CSM must learn, in a group, the emotional dynamic that characterizes their relationship, without implying the analysis of the overall working of the CSM. The idea of splitting the problems from the context that caused them, is very far from what GP, for some time, has been producing as a clinical psychology theory of the relationships within the organization and that it is implementing in practice as intervention. On this, see the elaboration of the methodology of "analysis of the demand" (Carli & Paniccia, 2003)[17]. If the CSM has conflicts and problems in communication, such issues must be considered as a symptom of its way of working. They aren't dysfunctions to treat, but potential resources for its development. The CSM seems to lack a shared strategy, that creates a feeling of belonging different from defensive cohesion, and permits the integration among roles; the interpretation of these symptoms, bad communication and conflicts, might help to develop a new belonging. We must not forget, at the same time, that dealing with communication and conflict as informations, and not as dysfunctions, produces important consequences, on the system of power in the CSM. If dysfunctions are deficits to solve, the power relations characterizing the organization are not discussed. Instead, if they are information, the power relations become the object of review and criticism. If bad communication and conflicts are information on the modality of relations characterizing a context, the whole of the modality of relationship among people, roles, functions, without excluding leaders and informal power groups, will be examined and discussed. This way of conducting the consultation makes the client, who has the power to commission the work from the psychologists, strongly involved in the whole process of intervention. Thus, this means the definition of goals, the discussion of the difficulties expected during the intervention where the power relationships are debated, the methods that will be adopted during the intervention, will be the subject of continuous confrontation, in order to reach an agreement among all the parties in the case: with the client on the one hand, and with all the persons involved in various ways, on the other. Moreover, to discuss the power systems of an organization makes sense only when the organization itself is adequately interested in pursuing outcomes with its client. According to the psychological theory we make reference to, we can say that an organization is interested in discussing its ineffective power systems when it actually feels that they are ineffective. Or, when, it wants to limit the omnipotence of its collusive fantasies being acted out within the ineffective power relationships, because it feels their destructive potential. In this case, in the organization there is an interest in knowing the working reality and the persons who contact the organization to obtain products and services. Thus the problem, also for the CSM, is to discover, during intervention and while the goals are being agreed on, if there is enough interest in the working context and in the client to make it feasible to set limits so as to disconfirm the collusive fantasies that are responsible for the conflicts and for the ineffective communication. In fact, bad communication and conflicts can become a resource for the CSM, when they indicate where the collusive fantasies fail.

It must also be kept in mind that some members of the CSM knows GP. Moreover GP has published their hypotheses on the intervention. There is also a more or less explicit hypothesis on the fact that GP usually intervenes treating problems as information. The fact that GP is known by some also has other connotations. If you know GP, you know that it refers to the psychoanalytical theory. Psychoanalytic practice characterizes the group of the "old guard"; the training director has shown some nostalgia for the past cohesion of the group. It would seem, that in fantasy, GP is a partial consultant. Moreover GP is composed of two physicians and three psychologists, each trained in the psychoanalytic and psychosocial approach. It thus contains two of the professions characterizing the CSM, and in conflict amongst themselves. Moreover GP is inspired by the French derivation of psychosociology. These matters must be kept in mind[18].

The intervention proposed

The GP has to respond keeping in mind all these conditions, not least the limited budget set by the CSM.

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[17] There is a large bibliography on this subject, and it is extended over time. For an up-to-date synthesis, see Carli, R., & Paniccia R. M. (2003). *The analysis of the demand: theory and technique in clinical psychology.* Bologna: Il Mulino.

[18] It will be interesting to observe that once the CSM has accepted the GP proposal to carry out an intervention based on the diagnosis of its way of working, it will never talk about "group dynamic" but it will choose to call the training, psychosocial training: a mediating term, in view of its many professional and theoretical identities.

GP discusses the case. When an organization reveals internal conflicts and does not say anything about its client, the diagnosis is of an embarrassing simplicity. It is a self-referential organization that implodes in itself, in conflict. In this way, it protects itself from the feeling of impotence it feels towards its client. And it also finds emotional satisfaction in the intensity, drama, predictability, and omnipotence of the conflict itself.

When the competence to deal with the client is lacking, the organization withdraws into itself and the internal conflicts, that seem the most important thing in the world, and exclude all the rest, explode. The client, one fears, may vanish without a trace. As its defensive demand the organization asks the consultant to be comforted and supported in its isolation. The collusive response allows this suicidal *expectation* to be accepted. The useful response helps the organization to return to its relationship with its client and with reality, in a more competent manner.

The diagnosis is easy, we said: the symptom is clear and evidence based. But the diagnosis can also be embarrassing in its uselessness for the CSM. How can it be shared with the CSM? How can one ensure that the CSM makes good use of it? Is the CSM interested in gaining knowledge of itself and its way of working or does it want to lock the consultant into its own collusive dynamic, the same that made it call in the consultant? Moreover, since until proved otherwise, one supposes that the CSM has such an interest, how is it possible to act within the limited resources available?

GP thinks of proposing a research/intervention to make a diagnosis of their organizational operation by means of the active participation of the staff. Participation in a process dealing with the knowledge of the way the CSM operates, thus of its dysfunctions and potentiality, will allow the staff to understand their own problems. The general principle that there is internal conflict when there is also incompetence in dealing with the client, will find a specificity within the CSM. Unless it immerges itself in this specificity, unless it is recognized within the employees' everyday work, it can only be proposed as a value, through advice, prescription and sermons, which we know to have little or no effect. GP, is, also sure that the identification of the specific ways in which carelessness towards the client is expressed, will make it possible to discover nor only the cause of the conflict, but also some guidelines for the development of the service.

The intervention is organized within the fifteen working days laid down in the budget.

GP also accepts the condition that only those who want to take part to the intervention, will do so; this is a problematic condition, because it could become a way of acting out the conflict among parts of the services.

It will be discussed in depth with those present for its symptomatic meaning, and with them it will be decided if this type of participation will make impossible to go on with the intervention. During a further meeting with the top clinician of the CSM and the training director, it is proposed to make a first reading of their demand.

GP therefore puts forward its hypothesis on the intervention. It is explained that the organizational diagnosis proposed is based on clinical psychological models of reading the relationship. These models will make it possible to understand the causes of the lack of communication and of the dysfunctional aspects of the conflicts. The training of the employees could be realized through their participation in collecting data on their modality of organizational relationship, and through the discussion of their interpretation.

To propose this kind of intervention constitutes a first test of the CSM's intent to know and to discuss their own collusive fantasies. The hypothesis is accepted, and, at the end of the meeting, the top clinician asks for a proposal.

GP puts forward a written proposal; the CSM accepts it. Three months passed between the first contact and the proposal to the CSM. Nine months will pass between the proposal and the assignment. The approval goes through the channels of the Department and its rules; and through the conflict between CSM and department. The intervention, considered as the presence of GP in the CSM after the assignment, discussing work with the staff, collecting data, analyzing and discussing it and returning it with a report, lasts three months. Two assessment meetings will follow between GP and the CSM, the first one two months after the delivery of the report, the second five months later.

The local culture of the CSM

After the acceptance letter, GP continues the consultation with a half-day meeting at the CSM, dedicated to the presentation and discussion of the intervention with the thirty-odd staff involved. Two physicians and a nurse are missing, and they will not take part. The others are present. The training director informs them that, day by day, since he presented the GP proposal to their colleagues, the support for the activity has increased. During the first meeting the agreement on the training hypothesis formulated by GP is checked. At a second meeting, a few days later, a series of texts on their working experience in the Service individually written by each person present, is collected. The training goes on by dividing the participants into two groups, asking them to state the problems and prospects of the services, and what they are expecting from the training. The discussion is recorded. A text must be collected to be analysed with a specific

methodology, the AET, Emotional Analysis of the Text (Carli & Paniccia, 2002), to obtain a map of the collusive dynamics, or of the local culture, characterizing the CSM[19].

The sequence of the individually written texts followed by the group recordings sets out to explore the possible difference between a culture expressed starting from an individual position and the culture collusively organized by the group. Later, within three weeks, GP analyses the collected texts and interprets the data obtained. The third meeting with the participants take place: a diagnosis of the CSM way of operating is communicated.

Let us look at the main aspects.

From AET we obtain a local culture mapping[20] (Carli & Paniccia, 2002) of the CSM. This culture is composed of two different but related attitudes. Among the different positions expressed, one emerges about what happens on the boundaries of the service, in the relationship between what is within the CSM and what is outside it. This is a relationship seen as fundamental, but in a deeply critical position, with the risk of failing. Note that the relationship in question is between the service and the potential client. It is not the relationship among a single professional and a single patient. It is not taken for granted that the person at the border of the service is a patient. S/He could be for instance, a member of the family, or one of the co-owners of a problematic person, an institution like a school or the hospital, or the family association.

This aspect of CSM culture shows what the demand formulated by the training director and the top clinician of the CSM, had left out: the relationship between the organization and its client. The importance of what happens at the borders of the service, and the difficulties in its management, tells us that the CSM problem lies in the relationship between organization and client. It is an organization that is not able to organize an effective relationship with its client, and it fails in that. The cultural map of the CSM shows that this way of representing the service is important. Its relevance confirms the hypothesis made by GP, that conflicts and bad communication derived from the lack of client orientation. This way of representing the service, is opposed by a second way, which expresses a dutiful culture, of what should be done in the CSM. It expresses the basic purpose of the social mission, in particular, to reinstate, and re-socialize the users.

The first cultural position represents what happens on the CSM borders and its relationship with the client, the second represents its inside and the reference to the social mission.

The pole of the inside and of the social mission represents a given social context, that is operating and conforming, where somebody, because his disorders or his difficulty adjusting, risks being expelled.

The culture of the CSM is represented along an axis that at one side, that of the first cultural position, sees an organization that must be constructed through the relationship with the client, and that must be negotiated through shared rules they are not able to find. This is the pole of crisis, impotence, lack of competence to deal with these demands. The discussion within the groups refers to this pole[21].

On the other pole of the axis, the culture of the CSM is represented by a cultural position that sees the social system as a given and conforming organization, into which the CSM leads its users. The individual written

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[19] AET (Emotional Analyses of the test) is based on the hypothesis that emotions expressed by the language are the main organizer of the relationship. The language, according to AET, is never an individual narration, but always a relationship organizer. According to that, the analysis has not as object the sequences, but the closeness, within a test segment, of words characterized by more emotional fullness and less meaning ambiguity. Emotionally full words are those of which the meaning is evident even when the word is outside the context of speech. Emotionally full words are, for instance, love, failure, ambition. Such words are called full words.

On the other hand, words like 'in', 'of', 'each', but also, 'to define', 'to follow', 'ambit', are not considered full words. They are in fact words with high ambiguity, that need the context of speech to make their emotional sense clear.

To continue with the analysis, the researcher, who has already obtained a full vocabulary of the text examined, selects the full words contained in it and rejects the others. Then, they are processed by a statistical methodology, that groups them into clusters. The cluster analysis and the factorial analysis of the space where they occur allows the collusive dynamic, or local culture of the text examined to be identified.

Carli, R., & Paniccia, R.M. (2002) Emotional analyses of the text: a psychological tool to read text and speech. Milan: FrancoAngeli

[20] In statistical words it is represented by a factorial plane and some clusters contained on it. The two different, opposing, cultural dimensions shown correspond to the two clusters that are opposite on the first factor. Here we only recall this aspect of CSM culture, identified by AET; it is however, a highly relevant aspect within the whole dynamic of this culture. We intend to make an analytical presentation of the analysis carried out, in a future paper.

[21] In a statistical sense, it is the relationship between the group discussion of the operators, assumed as illustrative variable, and a cluster.

tests refer to this pole[22]. When the CSM employees leave the individual dutiful position related to the social mission, being in contact with each other makes them experience conflict, but they also measure themselves, not without problems, with the CSM client.

Let us remember the supervision of serious cases, which is done in the CSM, during the intervention reported here. That is not were the crisis lies, nor the incompetence. From the research data, it is possible to suppose they have more tools to treat the serious cases already taken on, than for those they have to treat as new users. The AET tells us that whoever arrives at the CSM is called "people"; so evoking an undifferentiated, numerous and pressing mass. As for the training they wanted oriented to the group dynamic, in its self-referential dimension, it was defensive towards the present problem: the question in fact is not to take care of the inside of the CSM, but it is necessary to bring inside and outside together. The competence of dealing with a new demand that must be known, remains to be acquired. This demand calls for competence not only in care and assistance, but with advice in a broader sense. The dreaded family associations come to mind.

The diagnosis that GP proposed to the CSM ends up with the indication of three possible directions of development for the culture examined, to support with specific strategies and initiatives:

a) to shift from the self-referential culture to a client orientated one;

b) to articulate roles and functions, according to the client orientation;

c) to develop the competence of reading the demand coming from the local area.

After the third meeting GP draws up a conclusive report that also considers what the participants proposed during the discussion of the data, and gives it to the CSM.

Two verification meetings

Two months later, the training director asked GP to hold an intermediate evaluation meeting. Some critical events were pressing on their undifferentiated relationship model: on the one hand the necessity to define criteria for incentives distribution, on the other hand the frequent interaction with other services. The type of problem that prompts the CSM to call in GP, had changed markedly.

Five months later the final validation meeting took place. The CSM recognized itself in the diagnosis. Among the three guide lines proposed, the CSM is working on the second one: the staff is differentiating its functions. There is a passage from conflicts among professionals and individuals to conflicts among functions. The participants are bewildered: the outcome of the intervention is not the resolution of conflicts. Besides, for some aspects, the situation seems to be more complex and demanding than before. However, there is the feeling that they have to pass through it, from the articulation of roles and functions, and that they have to face the consequences. Some fantasies on their autonomy, declared at the beginning of the intervention, are remembered. Each one felt autonomous free to do as s/he liked, and at the same time, for the same reason, each one felt s/he was unimportant. Now it is no longer like that. Each one feels s/he depends on the others, but also that s/he can do something useful. They have started to accept requests that earlier they rejected, such as a request from a school. At the final validation meeting one of the physicians, who at the beginning had angrily refused to participate, is present. At the end he expresses his regret at his non-participation. Attending the meeting, means he wants to say he was wrong. GP is not, as he thought, a biased consultant. The intervention concludes with the feeling that it was useful, but too short. It would have been useful if the consultant had spent longer assisting with the development of the service.

The evaluation of the intervention

How was this intervention evaluated? We have three information sources on this subject. The first is this report itself, which gives the goals set, the modality used to agree upon them, the different moments used for evaluation in the course of the intervention and at the end. Furthermore, this report goes beyond its aim, and becomes an object the reader can read critically. The second evaluation source is represented by some documents issued by the ASL. The third one, the customer satisfaction measurement, carried out by GP.

The documents issued by the ASL.

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[22] In a statistical sense, it is the relationship among the individual texts written by the operators, assumed as illustrative variable, and a cluster. The text analyzed is the result of both the group discussion with the operators, and their individually written texts.

Let us start by analysing the documents. We are speaking about six documents, written by the general management of the ASL or by the CSM. They are given in confidence to GP by the training director, all except one, the fifth document, on the course evaluation[23], expressly addressed also to GP. They are:

1 – from the UORU[24] to the ASL. It is about the criteria that must be used to plan and carry out training activities in the ASL.

2 - from the CSM to the ASL General Management. The CSM ask for the acceptance of the course proposed by GP.

3 – from the Director of the Department to the CSM. It is about the planning of the training, of the course with GP.

4 – deliberation from the General Management of the ASL, concerning the course with GP

5- from the CSM staff, to GP and to the Department. It is the assessment report related to the training activities carried out, including the course with GP.

6 – from the CSM to the Director of the Department. It is the assessment report related to the training activities carried out, including the course with GP.

A brief review of these documents allows us to understand some cultural data concerning the ASL, hence the CSM. Representations of the competence as individual competences connected to the professional specificity emerge, while the organizational competence is lacking.

It is also possible to understand how the intervention proposed by GP interacts with this culture. The documents are also symptomatic of the relationship between the different agencies involved. For example, of the conflict between the CSM and the management of the Department[25].

1. The first document deals with the criteria used to realize and plan all the training activities in the ASL. The document is written by the human resources organizational Unit, which works in the staff of the General Manager of the ASL. The document allows us to understand the strategy orienting training in the ASL and the organizational agencies that conduct it. On the premise that all the training activities are destined to promote and preserve community health, it is stressed that they must bring out employees' capacities and aptitudes, over and above support the assuming of the responsibilities needed to promote the development of the health system. Over and above that: what is beyond, further away. There is no interdependency between the development of individual capacities and organizational development. Two separate aspects, far removed from each other, must be brought together.

2. The second document is the acceptance requested concerning the course with GP, submitted by the director of the CSM to the UORU of the USL. The proposal written by GP is attached to the document.

Aim of the course: to increase awareness of the operation models of groups and of the service, using a psychosocial methodology. It is added that improving the professional quality of the staff there will have an obvious impact on the users. The separation, already proposed in the previous document, of staff training, organizational competence and client-oriented activities is stressed. The impact on the client is so obvious that it is not worth mentioning. Moreover, the approach proposed does not discriminate among roles and functions: the course is for the whole staff. At the same time, the GP proposal is adopted that the training object should be the knowledge, on the part of the service, of its own operation modalities. The document becomes more detailed in the second part: the receivers are operative groups recently constituted, that carry out specific programs for the users. Four groups are pointed out in particular: re-socializing activities; half-way house; reception; quality. The last activity is connected to client satisfaction; as far as reception the users to the CSM is concerned, it will be the central critical event in the service. It is also declared that the leader of the operative groups and the whole service staff will take part to the training. The leaders are evoked for the first time: the not-discriminating approach of the service is expressed clearly. The investment on roles and on the assumption of specific responsibility was to be one of the more interesting outputs of the GP intervention in the CSM. After this meeting, many months later, the course was approved.

3. A third document, by the management of the department, includes the course proposed by GP in the annual training plan. The document, defining the general target of the GP course, reiterates the previous document, written by the top clinician of the CSM. The difference concerns the receivers: physicians, psychologists, social workers, nurses, sociologists, administrative workers. The professions of the CSM are named. The operative groups and their leader, recalled in the document of the head of the CSM, disappear. The professions, with their symbolic hierarchy, present in the order used to list them, replace the functional hierarchy. The culture of organizational expertise is weak.

4. A fourth document is the deliberation on the course, its acceptance, signed by the General Manager of the ASL. The ASL accepts the implementation of the course and allocates the budget for it. The goal of the

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[23] In all the documents, the GP consultation is called "course". GP is characterized by psychosocial expertise.

[24] The human resources organizational Unit, as staff of the General Manager of the ASL

[25] During the intervention, at the end of the nineties, the function of the Department as coordinator of its training activities, and also those oriented to the CSM, had just been created. The CSM considered the fact that the department took on this function, as a threat to its autonomy.

course: to improve the competences in analyzing the operation of the working group, to improve internal group dynamics, to improve the quality of professional activities. Receivers: the whole service staff, physicians, psychologists, social workers, nurses, sociologists, administrative workers. With few variations the culture that separates organizational analysis, group dynamics, professional services, is repeated.

Once more, roles and functions are ignored. A confused group of generic employees on the one hand, and on the other hand a sequence of professions, take their place. Further to this document GP receives the assignment, carries out the intervention and the final report is delivered.

5. A fifth document is the evaluation report, at the end of the two training courses carried out in the CSM: the supervision of serious cases and the psychosocial experience. The report, by the training director, is addressed to the head of the department, to the staff of the CSM, to GP[26]. Two goals are declared in it. The first deals with the inside of the CSM: there is the invitation to disseminate comments on the training initiatives and to monitor the first results of organizational improvement. The second objective is towards the outside: to inform the management of the Department[27]. The reasons why the CSM carried out the two training activities are summed up. Both a disease and an incapacity to solve it, were evident among the employees. In particular, as far the psychosocial experience was concerned, inside and among the work groups there was a permanent conflict, as reciprocal undervaluation; the risk of being unproductive was felt; the danger of burn-out was perceived; there was a difficult relationship with the organized users, the family associations. The work done with GP is said to stress the specific local culture of the CSM, generated during the year, and aimed at the regulation of relational and organizational processes. Critical events characterizing the operativeness and organizational operation were also studied. The relationship with the users was analysed. The relationship with the coordination structures, in particular with the Department, was considered. The document says that the comments regarding the models of the service's way of operating continued after the last meeting with GP, in two staff meetings addressed to expressing strategies on the critical point identified. In particular, they were working on the definition of responsibilities in relation to the different initiatives for the relatives and to their coordination. There was the intention to satisfy the relatives' demand. The initiatives had been disconnected up to that point. Moreover the head of the CSM had instituted a commission on training, designed to be in contact with the Department and put an end to the conflict.

6. A sixth document, specifically addressed to the department director, and signed by the training director, evaluates, once again, the CSM refresher courses. The document explains that the effects as regards participation, agreement, implementation of the internal resources, showed the necessity for the Department to go on to consider the needs declared by the CSM staff. Hence it seems necessary that subsequent projects should spring from the discussions between the service and the Department.

The customer satisfaction measurement

The third source to verify the GP intervention in the CSM, is represented by the data obtained from an evaluation form, proposed by GP and filled in by the participants, at the end of the intervention.

Eight aspects were submitted to a double evaluation, both for importance and for satisfaction. They were asked to give two scores, on a 1 to 10 scale (1= not at all important; 10= very important; the same for satisfaction). These were the eight factors: congruence among the goals of the intervention and the development of the organization; usefulness of the intervention for the organization growth; adequacy of the tools used by GP to achieve the goals set; respect for timing by GP; ability to understand the problem set by the client; professional competence of GP staff; relevancy and clearness of the documents provided; adequacy of the assistance provided. The average, among the answers to the eight factors, without significant deviation, between importance and satisfaction, was 8.5. Moreover they were asked to indicate on a 1 to 4 scale the global level of satisfaction towards the intervention. The average was 3.5. always on a 1 to 4 scale. They also answered the following question: We ask you for a prediction about your organization. In your opinion, is your organization in development? The average was 2.2. Thus, we have different sources to carry out an evaluation. There is the report, dealing with the foundation, the realization, the end of the

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[26] We notice that the assessment document is not addressed to the consultant who did the supervision on the serious cases. This activity remains symbolically separated by the organizational operation of the CSM, which is the main subject of the assessment document. Actually, the only training process discussed in the assessment document is the one implemented by GP.

[27] The CSM symbolically saw the department as outside the service; and so it is defined as outside in this document. The CSM is the inside of belonging, of seeing oneself as equal to the others, while the department is the outside, far from oneself, threateningly different. During the intervention the enemy connotation of the Department, useful for the preservation of cohesion within the CSM, was discussed at great length.

intervention; with the setting of goals, the resources and the methods adopted to reach them; with their evaluation. The report tell us which theoretical approach and categories the consultant used. There is a comment by the client on some documents, where strategies and goal are defined and where what has been done is evaluated. Lastly, we have the measurement of the CSM customer satisfaction towards the intervention. None of these data, however, including the latter, apparently objective, has any sense by itself. Nor do the different data arrange themselves as a coherent whole. There is an almost euphoric feeling expressed in the satisfaction forms as soon as the intervention ended; it would seem the discovery of a feeling that allows one to give a sense to the emotion felt in the CSM. But there are also other feelings felt during the last assessment meeting: tiring effort, disillusion of the fantasy of being able to free themselves from conflicts, the opening to new working prospects, the fear of reverting to isolation after the sharing sparked off by the intervention. Both the consultant, and the client, everyone his own way, are once more confronted with the necessity to go on with the interpretation. But this is precisely the outcome of a clinical psychology intervention.

This outcome agrees with the theoretical and methodological hypothesis of GP. The whole work with the CSM was guided by the hypothesis that the intervention operates on the relationship. The relationship is, on the one hand, organized by a collusively shared culture, and on the other, by the developmental goals of the relationship itself.

When recurrent critical events announce a break between the first and the second, a clinic psychology consultation can intervene. It works on the reorganization of the relationship dealing with the client's collusive arrangement and his developmental goals. These goals are, after all, not set as expected outcomes. Instead they have the function of methodological orientation. They are set as criteria that enable contact with the context variability and with the stranger, in a continuous process of exploration and interpretation. The triggering of this process indicates the intervention is being put to the test.

References

Burns, T., & Firn, M. (2002). Assertive Outreach in Mental Health: A Manual for Practitioners. Oxford: Oxford University Press.

Carli, R. (1998). Sanità ed Azienda: Riflessioni sull'organizzazione sanitaria [Health and Enterprise: reflections on the sanitary organization]. Prospettive psicoanalitiche nel lavoro istituzionale, 16, 3, 326-347.

Carli, R., & Paniccia R.M. (2003). L'analisi della domanda: teoria e tecnica dell'intervento in psicologia clinica [The analysis of the demand: theory and technique in clinical psychology]. Bologna: Il Mulino.

Carli, R., & Paniccia, R.M. (2005). Casi clinici: Il resoconto in psicologia clinica [Clinical cases: the report in clinical psychology]. Bologna: Il Mulino.

Carli, R., Guerra, G., Lancia, F., & Paniccia, R.M. (1984). L'intervento. psicosociale nei Servizi di Igiene Mentale: Un'esperienza [Psychosocial intervention in the mental Health Service: an experience]. Rivista di Psicologia Clinica, 1, 75 - 95.

Carli., R. & Paniccia, R.M. (2002). L'analisi emozionale del testo: Uno strumento psicologico per leggere testi e discorsi [The Emotional analysis of the text: un instrument for reading texts and speaking]. Milano: FrancoAngeli.

Correale, A. (1991). Il campo istituzionale [The institutional field]. Roma: Borla.

Desjarlais, R., Eisenberg, L., Good, B., & Kleinmann, A. (1995). World Mental Healt: Problems and Priorities in Low-Income Countries. New York–Oxford: Oxford University Press (trad it. La Salute Mentale nel Mondo, Bologna, Il Mulino, 1998).

Goldberg, D., & Huxley, P. (1992). Common mental disorders: A bio-social model. London - New York: Tavistock/Routledge (trad. it. Disturbi emotivi comuni, Il Pensiero Scientifico, Roma, 1993).

Guerra, G., & Paniccia, R. M. (1987). Analizzare la domanda: Un caso di intervento in un servizio di diagnosi e cura [To analyze the demand: an intervention in a SPDC], Rivista di Psicologia Clinica, 1, 54-64.

Refolo, G. (2001). Psichiatria prossima [Next psychiatry]. Torino: Bollati Boringhieri.

Thornicrof, G., & Tansella, M. (2000). Manuale per la riforma dei sevizi di salute mentale [Handbook for the mental health service reform]. Rome: Il Pensiero Scientifico.