The function of psychotherapy in Italian Mental Health Services: Experiences of traineeship.

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Abstract

This study is a remark about the cultural change psychotherapy has brought in the running and in the social image of Italian Mental Health Services. Here, two kind of mental health services will be examined, Centers for Mental Health (CMH) and Hospital Psychology Units. Originally, both services were not arranged to provide for psychotherapy practice. The following work aims at contributing to the ongoing critical reflection on the running of mental health services by focusing on a particular issue: what are the goals of psychotherapy in a Center for Mental Health or in a Hospital Psychology Units? What kind of competences does it require? The thesis that will be formulated through the undergoing of clinical experiences will confirm that the construction of the function of psychotherapy within these two contexts cannot be mere imitation of private practice, but it requires a specific organizational competence.

Key words: psychotherapy, services, admission, demand

The following work aims to explore the sense and the implications of psychotherapy within public mental health services. We'll go through their rise and historical growth reconnecting it with a series of cultural changes which gradually resulted in a new kind of demands to Italian Health Care System.

First of all it's interesting to reveal how *psychotherapy has developed in contexts whose strategic goals were originally different,* that meant to treat problems throughout the activation of the whole service. This required the need of specific organizational skills within that context.

In particular we refer to two kind of services we had the chance to better know as trainees such as the Centers for Mental Health and the Hospital Psychology Units. In the above mentioned services psychotherapy was something new compared to those already existing. Let's see how.
Centers for Mental Health raised in Italy after the approval of the law 180/'78, with 833/'78 health care reform that provided the territorialisation of mental health services[1]. Psychology units used to serve instead as service facilities for hospital wards.

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[1] Italian Health Care Reform 833/'78 extended former law proposed by Franco Basaglia. That law didn't include notes for the rise of mental health care territorial services. Health care reform aimed to abandon the asylum institution through the regulation of compulsory treatment in hospital. In this way lunatic asylums were replaced by specially provided hospital units for psychiatric diagnosis and treatment to be provided inside public hospitals (SPDC) and connected with a system of non-hospital services.

After the closure of the asylums, the Centers for Mental Health dealt with that part of the population defined as psychiatric patients (ex in-patients), in terms of prevention, treatment and rehabilitation of mental diseases. Psychology Units instead aimed to be a resource for facing new problems in the hospitals so that they would be later filling the gap between patients and health care system.
These two missions, as mentioned above, involved different professional figures within a single service such as nurses, psychologists, psychiatrists, specialists etc. The same happened for the different services in the territory such as therapeutic communities, day-care centers, SPDC (Psychiatric Diagnosis and Treatment Service), hospital wards etc.
So, along these mandates, psychotherapy started to diffuse in both contexts as an independent core to the services, regardless of the integration of different specialists, functions and facilities as if the richness and the complexity of all these relations wasn't regarding psychotherapy work.

How do we get to psychotherapy? Let's take a step back.

The development of psychotherapeutic supply in the services results from the concatenation of several factors.
Apparently, a relevant factor was the rise of successful psychotherapy schools. In those years, in fact, these schools filled a gap in the public supply of postgraduate vocational training which allowed a lot of psychologists to put themselves up for the job market with technical competence. This resulted in the prospective to introduce psychotherapy in the services as a possible supply to new demands that the services themselves were starting to receive.

Starting from early ‘80s, while Italian health care facilities began to involve psychologists, this rising role progressively provided a response that seemingly encouraged the rising of demands for therapy treatment. As we'll see soon[2], nowadays, such demands are listed in the services as "common emotional disorders".

The achievements of the psychotherapy practice in the Centers for Mental Health used to enable health workers to discuss typologies of intervention indicating possible evolutionary processes in the patients. This went against the static view of chronic psychiatric disorders as consolidated in the services.

According to our hypothesis, this is why in that period the services started to reconsider the role of mere places where those psychiatric disorders were treated, contributing this way to promote a new culture of mental distress as not necessarily related to the mental illness.

By "common emotional disorders", we mean all those problems belonging to the category of depressive and anxiety disorders touching a large part of the population. This turns out to be a new typology of unexpected and undefined demands to the services. We're talking, as said, about demands that are distant from the social traditional mandate of psychiatry, the social rehabilitation of mentally ill patients and occur following a brand new modality. In fact, an increasing number of clients, that is as high as never before in health care facilities, start to approach directly the services for a large set of problems. Often the demand may report to other uncommon figures for the psychiatric circle, like general practitioners (Paniccia, Di Ninni, & Cavalieri, 2006). It seems reasonable to assume that the services were to deal with changes of their own function and their social image. Based on these changes, they started rethinking critically their own epistemological models and their operative strategies.

An evidence is also given by the function of the admission of demands for psychological and psychotherapeutic counselling. In fact, this service joined the existing wards counselling in

[2] Cf. essay by Prof. R.Carli in this number.

hospital psychology units. Admission process is carried out as an outpatient practice according to the citizens' demands to the psychology units. Apparently it has its origins in clients who used to have experiences with the hospital environment where those unities are.
These changes have been little discussed so far and many ambiguities still persist. We will thus try to introduce some codes for reading these ambiguities according to our experiences in the services.
As already mentioned, the members of our working team are doing their traineeship in seven Centers for Mental Health and in one Hospital Psychology Unity.

A helpful criterion for reading the different organizations of the services along the territory, is the demand through which they get activated.

Let's take the Centers for Mental Health as an example. Two tendencies seem to be in the facilities we have known along our traineeship. The first one is oriented to mostly deal with demands reporting to social contexts (families that cannot live any longer with one or more of its members, conflicts with neighbours etc). The second one mainly deals with demands from individuals who approach the service because of personal difficulties.
Simplifying (cf. the table below), we could arrange the services on a continuum based on the prevalence of one of the two poles of the demands. Such a placement evidently affects the goals and the methods. In fact, while social integration of the psychiatric patients aims to improve their relationships and implies a network that includes different "actors" (patients, families, services and partnership in the territory, job market etc), on the opposite side the counselling usually occurs within a face to face psychotherapy process.

Center for Mental Health		SERVICE	**Hospital**	
Demands whose clients are the social contexts	Demands whose client is a single individual	DEMAND	Demand of a hospital unit	Individual demands
Organizational response	Individual response (psychotherapy)	IMPLEMENTS	Organizational response	Individual response (psychotherapy)

On one side is the systemic organizational response, given by the organization as a whole; on the other side is the individual response given by the health worker.

A privileged point of view to consider the two different functions of CMH and Hospital Psychology Units seems to be admission process, as it is the first contact between services and new demands. In fact, it reflects the way the services symbolize the demands and the way they think and organize the intervention as a response to the demands.

In particular, it's interesting to study how admittance has been increasingly implemented in the services as a consequence of the variability of common emotional disorders. This new field about the demand makes the services operate a change of their epistemological model shifting from *diagnosis and care of the mental illness* to the *analysis of the demand* that is oriented to identify personal development targets together with the client.

The fact that this new kind of demand cannot be immediately translated into psychopathological categories makes common emotional disorders not immediately treatable with an unambiguous and completely shared method. This is the way we read a strong crisis that is crossing the field of admittance in the services nowadays.

This issue appears to be as following:

-when the demand can be easily placed in the area of psychiatric pathology, it appears to fit both the rules and the culture of CMHs. This results in an easier response to the demand.
-instead, when the demand pertains to the area of the common emotional disorders, the response becomes a little more complicated, since these disorders, due to their variability, seem to require further organization of the admission-evaluation process, in which the patient and the health worker agree, on an ad hoc basis, on the program the services may offer.

The admission process may thus become an instrument of knowledge of the demand and verification of its relevance to priorities and resources of the service. The intervention sometimes coincides with this re-elaboration and re-consideration of the demand. Some other times instead it will be the basis for late decisions. This procedure could constitute in any case an opportunity for the services to work for the construction of shared reading criteria based on the problems addressed. These problems should result in a careful assignment of the cases to one or more health workers with specific and different competences also considering their preferences and scientific interests. In other cases the admission process could be faster so that assignment could be based on other criteria such as distributing equally the clinical case, in rotation. In the latter, there often is no time for health workers to discuss the case and question whether the demand is pertinent to the goals of the service.
The lack of shared criteria that read common emotional disorders can certainly undermine the capacity of a systemic response from the service. Therefore it's important to explore the way the services translate the demands into problems to solve.

We believe here that there are two main ways the services treat the requests of the patients. In the first one the attention is focused on the events and on the symptoms the patients use to motivate their need of help; in the second one the attention is focused instead on the way the problems are exposed to the service and on the emotions that organize the sense of the need of help.

Facts and emotional experiences. Those who deal with the admission process in the service use these two major categories to read the demand. This is a relevant difference because it affects the way the service arranges its intervention. Here are two examples.

Research of the "facts", comprehension of emotional experiences - Case 1.
Marta is sent to a hospital psychology unit by her psychiatrist who works in the same hospital and who has diagnosed her with a second level depression, developed after a tumour operated one year before.
During her first phone call with the psychologist who will be on this case, Marta expresses her disappointment about the fact she had to pay prescription charges while she expected she was exempt of them, since she lives on the disability after the tumour, the reason why she's here today.
The psychologist proposes to talk personally with her because she thinks that exploring the sense of that complaint may become a source of useful information about the way Marta is approaching her psychological session. During the next interviews we will see how she is using her disability to delegate to her illness the reason of her need of psychological assistance. Exploring the symbolic dimension of this behaviour will allow us to open new working areas which are not necessarily related to the illness.

Research of the "facts", comprehension of emotional experiences - Case 2.
Giovanna, 31 years old, comes to a neighbouring CMH and asks for an appointment. The nurse who fills in the admission form, writes down that the reason for this assistance is "a recent bereavement" (her mother died 3 months ago). Difficult relationship with her sister. Weight loss.

The few elements on which the service starts working are the “facts” (bereavement, weight loss) that immediately recall a possible diagnosis of depression. From here the patient will be assigned to the psychologist as she has explicitly asked for. The psychologist’s first interviews will be conducted with a trainee psychologist who has been working in the service for a few months. From the third interview on, the trainee psychologist will take care of this case.

We’ll keep talking about Giovanna’s case later on; now we highlight that in both cases the first consequence of the importance of the facts is the diagnostic classification of the patients. We highlight this because our hypothesis is that the relationship between the patient and the service completely disappears if admission process only aims at making a “correct diagnosis”.

What happens from the moment one approaches a service?

If we take a look at psychotherapies, we see the risk that the services might join a model of psychotherapy that follows the private practice. This model is in fact characterized by single psychotherapists using specific techniques. The whole service’s attention thus, is not focused on the problems to get to a shared reading. We refer to this as a risk because compared to private sector, in the public sector the demand is more bound to the problem that motivates the request for assistance. In fact, while at the beginning of a private psychotherapy the wish to have an experience with a specific practitioner may be sufficient, in public services the patient, after presenting his problem, waits for the admission centre to decide his/her access to psychotherapy knowing neither the practitioner nor the method to be used.
Despite of this, it seems that from the moment of admission, the service tends to disappear, the patient tends to belong to this or that psychotherapist, unless the case raises issues that make the person in charge to discuss them in the staff meetings.
In this way we think that the service misses the opportunity to deal with the case in terms of a demand addressed to the service itself.

The organization, intended as differentiation of its functions, might represent a key instrument. However, if organizational and psychotherapy competences are split, there’s a risk to create a technical working area (for instance psychiatrists and psychologists) which tries to avoid contacts with the client by asking part of the service (mainly nurses) to act as a filter on the demands.

In this regard, the main instrument the psychotherapist has to understand the patient's demand, both in a private and public area, is the way the *treatment care relationship* is symbolized. Necessary elements for the comprehension is all the information, structural one included, which connote *therapeutic supply* in a service. We argue that in public area context elements *have the same role as setting elements in private sector.*

Here is a case upon which one of us has worked into a CMH. A patient who has already had his first interview, knows he would be followed by a trainee. During a phone call with the service when he says that he will be missing next interview, the patient *finds out* that the therapist is *only* a trainee not even well known to the other health workers. This element will affect the therapeutic relationship in following sessions. Is it possible to disregard this context information? Does this put a limit or is a resource for the intervention?
Our hypothesis is that the way the role of a trainee/therapist is symbolized could be vital information to understand the patient's demand unless the therapist considers it as private matter in a way he/she colludes with the patient’s interpretation of the circumstances. It should instead become an organizational data. Let's imagine that the patient lives the therapy convinced he is being considered as "a second-rate client" who deserves only one trainee while the trainee feels as a "second-rate therapist". Let's consider instead the opposite way around, the sense of *inferiority* is felt within the relationship and relates to the problem that has motivated the demand for therapy. There is a huge difference between the two situations.

Research of the "facts", *comprehension of emotional experiences - Case 3*.
Let's see another case we've met going through our traineeship in a clinical psychology unit. Lorenzo, married, thirty years old, with a three year-old daughter, working in computer science. He shows up for the first time with his wife Sara for their daughter's follow up. She was born pre-mature and has been followed up for three years in the service.
The "follow up" is a function that psychology unit serves under Neonatal Intensive Care Unit mandate, where both premature newborn infants and in term birth infants are treated for different pathologies. It starts since the baby is released until he is five. Follow up is both a long term monitoring phase of preterm births and a space for parenthood counselling on premature births.
During follow up Lorenzo talks to the psychologist, who coordinates this activity, about hard period the couple is going through. They have been going out together since they were 13 but now think of getting separated so that they need some help with how behave with their daughter. The psychologist suggests Lorenzo and Sara to attend parenthood counselling sessions.
After early interviews, the psychologist catches the anxiety this married couple has in facing the crisis of a symbiotic relationship. So she decides to talk about it with two trainees with clinical training, thinking it could be useful to explore Lorenzo and Sara's demand as it is not about following them up only as parents, but as a couple as well.

Lorenzo and Sara are presenting a problem which can't be totally classified in the *area of parenthood*. Lorenzo has clearly used the "follow up" space as a pretext to talk about the problems he has as a married couple with Sara rather than talking of the problems of the couple as parents.
What's the service organizational response to this new request?
The psychologist who coordinates the follow up agrees with both trainees on suggesting Lorenzo and Sara individual admission interviews. Both are interested in doing so. Let's now take a look at the meaning that admission interviews may have in the work that the service has started with Lorenzo. Since early sessions with the trainee psychologist, Lorenzo's proposal of relationship seems to reproduce the organizational dynamic that characterizes the relationship between premature infants' parents and Neonatal Intensive Care Unit. Premature infants are taken care of while the parents are trained until they are able to take care of their children once out of the hospital. Lorenzo seems to expect the psychologist to teach him how to behave. During the interviews it's particularly hard helping him to give up his passive mode in the relationship with the services. However, thanks to the work on emotional dynamics that marked the relationship between Lorenzo and the psychologist, it was possible to explore the problem Lorenzo had posed to the service that is his fear of "not existing" but conforming to the others' expectations.

Therefore, it was useful that the service hasn't considered Lorenzo as a parent in need of instructions, following a restrictive and rigid view of the goals of the unit. We think that Lorenzo's problem would have never been understood by the psychology service if his request to become "a good father" hadn't been explored but reified conforming to the institutional practice of the parenthood counselling.
In this sense, understanding *where* we are and *who* we are when practising psychotherapy helps to know what is happening in therapeutic relationship. Understanding the organizational dimension that characterizes the operative context where the demand arrives is key factor for the specialists' response and for the way they approach the counselling.

Following the distinction between facts and emotional experiences during the admission, a particular attention to the context dimension thus is given in psychotherapy. In the services, psychotherapy cannot operate out of context as imitation of private practice.

Let' s look back at Giovanna's Case 2. Here, early diagnosis of depression, first assumed as a problem to be dealt with by a single psychologist, converted later into a relational dynamic involving SPDC and two psychiatrists from CMH. An interesting aspect is that the service tried different ways to keep up the relationship with the patient despite her frequent attacks, and did it by reorganizing its early plans.

This aspect can be further explored by revisiting the different phases of the intervention starting from the admission.

As we have already said, Giovanna is 31 years old and approaches a CMH following her aunt's advice, who has noticed she's depressed. The nurse notes down that the reasons why this intervention is requested for are bereavement and weight loss.
Ten days later, during her first interview with the trainee psychologist, Giovanna talks about her malaise as a result of breaking up with her boyfriend Roberto. He doesn't accept anymore Giovanna's behaviours such as her continuous requests on assuring her about their relationship. The loss of both her parents adds to the problem of breaking up, her mother died three months before after a long illness and her father died six years ago by a stroke. Giovanna says that Roberto has supported her to get through and out of her losses and encouraged her to go out and get some distraction. She says she is in trouble in coping with this moment and that she can't recognize herself anymore in her attitude towards Roberto, like persistent phone calls and several provocative text messages to control him all the time. Giovanna manifests the same relational aspects with the two psychologists since by the end of the first interview she urgently needs another session, waiting seems to be so hard for her as well as following certain rules.
During later sessions, after resuming her affair with Roberto, Giovanna refers she has ambivalent feelings towards her boyfriend that are addiction on one side and distrust on the other. The way she faces the relationship with the others is also clear with the psychologist. Moreover several times she cancels her appointments.
First of all we start working on Giovanna's experiences, on her need of controlling the other. She seems not being able to keep a stable relationship until she acts out her uneasiness. Twice she tries to commit suicide by swallowing overdose of anxyolitics resulting in a hospitalization at SPDC. There she receives pharmaceutical treatments and joins a therapeutic group.
As a mental health care service, the CMH is also working with her family, her sister and her aunt. This work had already begun during SPDC hospitalization by a psychiatric and a social worker. This intervention aims to make both members of the family aware of the significance of Giovanna's actions and behaviours in an effort to help them to find a better way to relate to her.

We find this case is interesting in respect to some key points.

Giovanna's early demand seems to belong to the sphere of common emotional problems, an individual demand, treatable thanks to a psychotherapist. The attempted suicide activates most of the mental health care service, SPDC joins together with some psychiatrists from CMH, one of them heads a therapeutic group where the patient gets involved while another one deals with the regulation of the pharmacological treatment prescribed by the SPDC. Moreover, it's important to highlight how the Mental Health Service, especially those who deal with the admission, focuses on the problem shown (the facts) by Giovanna. Central problems seem to be the bereavement happened months before and the weight loss together with the complication of hard relationship with her sister (the issue arouse during her first interview). All these matters will take second place during the future work with the psychologist.
Our hypothesis is that in the relationship with the service and the psychologist, Giovanna might have acted out a relational proposal which is strictly connected with the problems that will lead her to attempt suicide. The patient's very little tolerance towards the limits of reality - as for instance the services waiting times - and her troubles in the relationship with the psychotherapist seem highlighting as a central issue, a relational dynamics based on the

fantasy she can control the others and the reality (Carli & Paniccia, 2002). This powerful fantasy vanishes due to traumatic events such as the mourning for her parents and the end of the affair with her boyfriend. All this is intolerable and unacceptable to Giovanna. Hence, the depression experience which had been highlighted during the admission could be read as an expression of the frustration of her fantasy to control the other.
The patient's relational proposal steers to a psychological-clinic intervention; in other words it's the symbolic dimension of the demand which becomes the object of the therapeutic project. This is the reason why the admission process becomes a crucial moment.

Finally, let's see another case where apparently the demand is presented as a responsive anxiety to life negative events. The diagnosis is quite detailed but the service will not use it as the only organizer for the relationship with the patient or for the intervention.
Antonio, 48 years old, comes to the Mental Health Service due to anxiety and a hard time sleeping. The first interview is made by a psychiatrist working in the admission staff, whose methodological instrument is the Analysis of the Demand. According to the psychiatrist Antonio doesn't need to receive psychotropic drugs treatment; rather he will enter sessions of psychological counselling with a trainee psychologist.
During his first session with the psychologist, Antonio says he has approached the service because eight years ago he suffered from a panic attack. Since this was a very traumatic episode to him he fears that his anxiety is a warning of another crisis to come. He also tells the psychologist about two other frustrating episodes he has been living for a long time. For ten years, in fact, Antonio and his wife have been trying to have a baby. "Since this was not possible naturally" they decided to apply for national and international adoption, being continuously under exam and interviews. Despite their attempts up to today still they haven't got a positive answer and the situation seems it is "stuck". Antonio refers he feels "drained" because of this experience.
But there is another criticality. Recently Antonio and his wife have taken legal proceedings against his wife's brothers because of inheritance matters. He says he is furious with the idea he can't get economical resource he's entitled to, which could help them to make their plans true.
What kind of emotions does Antonio manifest in the relationships with the psychologist?
Let's analyse the dimension of "potential" (like potential economic resources) that here is emotionally converted into "im-potence" that is not being able to transform or not being able to unfreeze one's own credit. The relational proposal organized by the demand could be understood through the neo–emotional category of *claims.* Antonio and the psychologist agree on starting weekly counselling sessions for eight times but Antonio says he cannot guarantee he can attend every week because he has lately got a new job so that he can't know how busy he will be. He *claims* the psychologist's availability with no reciprocal deal. He also claims that his life at work remain out of the interviews, as it is a separate sphere he lives outside, imagining that only his family problems will be discussed with the psychologist. The psychologist asks Antonio to understand what the symbolic meaning of making appointments for the counselling is. It means sharing the engagement in dealing with an important and interesting problem.
As Antonio approaches the service in a period when he is experiencing a growth in his career, then on this dimension an emotional investment can be made and the psychologist could help him to recognize the experiences he uses to face this change. Antonio will say that he is not satisfied of his job, he is an agent from a fashion industry and even though he is very devoted to his job and his work is widely appreciated, he feels he's doing this only because it is necessary.
Also in relation to the psychologist Antonio behaves as he has no desires, during his early sessions he always acts in a characteristic way. As he arrives he sits down saying with a smug smile he has kept the appointment although it was a hard job. He keeps silent and then adds: "tell me something, I don't know what to talk about". He thus wants the psychologist to tell him something interesting, suggesting him a topic to talk about; he assigns her the power to manage the relation, but also expects her to depend on him and feel gratified only because he consults her. Afterwards he will demand the psychologist to justify his claims to his wife's

relatives or do or say something that can give him a new hope. He expects her to repay him with powerful and beautiful words for what he expects from his wife but she hasn't given him.
If the psychologist had colluded with Antonio's claims, assuming the emotional role of the "expert" in the therapeutic relation, the relationship would have probably suffered a set back with no way out. In fact, those who claim something do not look for satisfaction. The claim aims to possess the other within the relationship and fails to permit that relationship gets something else (Carli & Paniccia, 2002). Not colluding with the claims is emotionally very hard so that the psychologist has been continuously challenged since she was invested with power and threatened by Antonio's distrust of her sincerity and capacity to understand him. Therefore even the power delegated to the psychologist was actually "potential", as in a constant challenge of being revoked, out of the relationship (being there but not being there at the same time as a modality of ambiguity) as a modality to isolate the productivity and the realization of the frozen resources.
Hereinafter, it has been possible for Antonio to stop identifying himself with his claims. He also laughed with the psychologist about his omnipotent expectations and started to sense the costs of this way of symbolizing and act out relationships.

We think that reported cases represent good evidence to further consider the typology of the demands that Centers for Mental Health and Hospital Psychology Units receive.
Often, a common central problem seems to be that of the loss, strictly connected with the emotional experience of *impotence*. What's the meaning of this emotional dynamic? Impotence means to lay down arms, to fail to face a conflict. Therefore, the conflictual impotence seems to be an answer to omnipotent fantasies. Also, common emotional disorders, those common problems which are presented to the service, are the expression of experiences of impotence and loss.
In this sense we aim at treating the loss not by finding a solution, rather by thinking together with the patient how he/she relates and feels with the loss. For instance, Giovanna and Antonio's problems shape around omnipotence/impotence core, being and not being in the relationships as a sort of control and thus omnipotence. The same is the attempt to suicide, which is the peak of omnipotence since it cuts you out of the relationship.
This short excursus into the demands addressed to the services defines an interesting scope of the investigation. If the problems why people go to the services are seen as a resource for its global running, they can provide the categories to map critical situations of a territory and allow to identify precautionary measures.

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