

Short-term psychological intervention and new demands in Mental Health Centers

by Roberto Vari*

Introduction

Nowadays CSMs (Mental Health Centers) can hardly develop suitable operative patterns and procedures to keep up with the new issues and the evolution of the demand.

Paniccia, Di Ninni and Cavalieri (2006), highlighted two historical cultural trends informing CSM¹ operative patterns: 1) Militant ideology, prevailing in the first period, characterized by a de-institutionalizing culture and by sacrificial, oblatinal attitudes which don't require any verification; 2) Technicality, where the therapeutic relationship is characterized by a feeble patient relying on a sound, skilled specialist.

Both procedures, scarcely considering resources and organizational structure, are not able to match the changing reality. The self centred attitude of the schools of psychotherapy and the inclination to self-legitimation within their technical knowledge, together with the renunciation to pit themselves with the check of their doings, have resulted in a stalemate. Even if in a confused and contradictory way, the policy of corporatization of the National Health Service has drawn attention to the inevitable consideration of economy and resources. Healthcare professionals are getting more and more conscious of the limitations imposed by the scarce rationing of resources and by the need to rationalize the actions and to set the priorities (Scala, 2007). In spite of that, this awareness does not result in consequent procedures. Proposals aiming at saving resources remain within repetitive clinical and organizational patterns, inclined to technicality.

For example, the proliferation of group psychotherapies provides a setting which allows to see a number of patients² in the same time unit. They are set without caring too much about their meaning, their aim or their effectiveness; in the same way no check for the outcome is felt as necessary. These groups often become self-referential, they get on with the same patients for years – which represents no resources saving – and their only aim seems to become their own survival. Even the practice of the short-term psychotherapy does not lead to the expected results whenever intended as a mere contraction in the time-frame, actuated without any reflection on the implied clinical and organizational paradigms. More than the outcome of a tested project, the effectiveness of such practices appears expectably legitimated by the existence of reference theoretical models and of relating training schools. In these terms, both the group psychotherapy and the short-term psychotherapy turn out to be ready-made therapeutic packages to be provided in a “modern” Mental Health Center. As such they appear ineffective instruments to face the resources shortage.

Starting from an experience carried out in a CSM (Mental Health Center) in Rome, this work proposes a reflection concerning the clinic and organizational framework which makes the short-term psychological practice possible in the Mental Health Centers.

Here will be briefly illustrated the climate present in the Mental Health Service before the constitution of a working group on “Patients Admission Process And Brief Interventions”; further on,

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¹ The CSM (stands for Centro di Salute Mentale: Mental Health Center) is a multi-disciplinary territorial service where psychologists, psychiatrists, nurses and social workers operate. It aims at preventing, treating and rehabilitating and it is open 12 hours a day. It is part of a network of services like Centro diurno (Day Center), Casa Famiglia (Group Homes), Comunità Terapeutica Residenziale (Residential Therapeutic Community), S.P.D.C. (stands for Servizio Psichiatrico Diagnosi e Cura: Psychiatric Diagnosis and Treatment Service). All together they constitute the DSM (stands for Dipartimento di Salute Mentale: Mental Health Department).

² We make use of the term “patient” conscious of the fact that it evokes a medicalized model of psychology which we do not share. However, we have preferred keeping it as part of a communicative system commonly shared in public services.

this group's aims will be mentioned and the short practice will be considered more in details describing the operative clinic framework; finally a couple of clinical cases will be presented.

Organizational Climate in the Mental Health Center

The formerly illustrated issues appear evident in the following experience of our Mental Health Center. The climate in the Service was characterized by a high degree of the so called "feeling of saturation". Going back to the Mental Health Centers history of the last decades, it appears as a diffused, largely shared feeling, often outlined as a "burn out indicator". The healthcare professional feels he/she can not provide a therapeutic response suitable to the customers' pressing demands, which he/she can not avoid on the basis of his/her institutional mandate.

Riefolo (2001) proposes saturation as the inevitable characteristic of the setting in the Mental Health Services, objectively connoting it as a disproportion between supply and demand. According to us the feeling of saturation represents, conversely, a mental state consequent to the denial of the context and of its limits and to the failed connection between therapeutic procedure, context and resources.

Another aspect associated with the sense of saturation in our Mental Health Center was the lack of time to spend on reflection. The difficulty in thinking was legitimated by the excessive workload. The clinical briefings were often disregarded for the most diverse pretexts, notably the contemporaneous clinical interviews scheduled during the time planned for the meeting. In the daily work prevailed repetitive action, thoughtless and only resulting in sterile complaining.

The feeling of saturation resulted in persecutory fantasies concerning both the healthcare institution - which cut the staff and the resources while increasing the demands on the personnel - and the new patients, potentially experienced as invasive. More than someone thought that inappropriate requests were accepted. The fabric of society itself, perceived as unable to integrate uneasiness, was blamed for the increase of demands overflowing to the Mental Health Center causing difficulties. The latter, however, did not act as a dialectic pole and interlocutor of the territory, but it kept on entrenched in an outpatient practice dimension. In other circumstances the persecutory feeling manifested internally, with possible conflict among professionals and groups of workers concerning the distribution of the workload.

In the meantime, since the introduction of new contractual regulations, the Health Service had been articulated in areas and sectors with corresponding assignment of a coordinator. The introduction of criteria of accountability through the responsibility assignment to staff could have represented an opportunity, in the presence of a unifying and integrative project; conversely, it declined towards a multiplication of self-referent watertight compartments that caused a further fraying of the Service and an exasperation of the individualistic and narcissistic components. In the meantime the dissipation of energies and the sense of saturation increased.

Only some of the aspects informing the culture of the Service have been so far exposed, others – however important – being omitted with the risk of losing sight of complexity and of being reductive. The aim here was to give an idea of the organizational climate and to point out the presence of a remarkable difficulty in working by objectives and verifications. This concerns repetitive collusions deserving a deep analysis which is not the objective of this study. Carli and colleagues (2008), in a recent research on Italian Mental Health Centers, have widely depicted the mentioned issues.

Setting up the "Admission Process and Short-Term Interventions" Work Team

As already stated before, the therapeutic relationship in our Mental Health Center was mainly established without any consideration of the planning and organizational dimension. The plan turned out to be identified with the practiced techniques: the pharmacologic treatment, the individual, familiar, group psychotherapy, etc. The testing of the practice, accordingly, was systematically disregarded. The therapeutic relationship lasted long with a tendency to become

chronic and ritual, while both parts of the therapeutic couple seemed to lose the sense of their relation. About 30%-40% of the patients dropped out in the course of the first year. The chronicity of the therapeutic relationship ended up increasing the sense of saturation, in a kind of vicious circle. Starting from these assumptions was born the idea of setting up a team caring about the new patients and reconsidering the chartering phase of the therapeutic relationship in a critical way.

In Mental Health Services, admission process has received special attention and a number of questions have been raised for years. The debate on this topic has proceeded in parallel with the changing kind of demands. The latter have increasingly expressed relational problems more than pathologies in Services still defined as psychiatric, unprepared to give up the identification between Psychiatric Service and place for Psychopathology Treatment. As a matter of fact, in the debate on admittance, someone still questions that the Mental Health Services should deal with “non-clinical” problems, evidently referring to clinical problems as the symptoms of the psychiatric nosography. Setting up as a novelty, the new demands have queried this cultural model and could be perceived as perturbing. As a consequence, before the experience of our work team, in a conservative perspective, admittance process was often figured out as a sort of protective filter to interpose between the users and the Service, aiming at restoring order where disorder reigns. It is impossible to analyse in details the debate on this topic in this space. It has often resulted in the multiplication and experimentation of practical and organizational arrangement without any reflection on the implicit clinical models.

The following ones are the thought guidelines informing the constitution of the clinical work team operating admittance and short-term interventions.

- Establishing in the Service a space where it is possible to reflect on the chartering moment of the therapeutic relationship, respecting the different professional background and procedures.
- Combining the detailed inquiry of the problems shown by patients with the analysis of the meaning of their relational therapeutic demand, that is the mirror of their problems (Carli & Paniccia, 2003, 2005). The primary aim is to avoid acting out, automatisms and short circuits that generate failure and waste of resources. The interdependence between demand and crisis of the current relational context – in turn often related to recurrent problems in the life cycle – assumes central importance³. The final aim of the admittance phase is the construction, together with patients, of a new reading perspective of the crisis originating the demand. This reading hypothesis will have preliminary and organizational value considering a following possible therapeutic plan. The organizational planning dimension is thus recovered and built up with the patient instead of being predictably generated by the technique. In such a way are laid the foundations for a possible verification of the interventions.
- Representing the chartering phase of the therapeutic relationship as a connection between the patient’s problems, the health professional’s competence and the Service contingent resources that are dynamic elements, peculiar to a continuously evolving operative context. The limits and the resources of such a context are attentively considered. Limits are no more experienced as a persecutory interference as opposed to idealized therapeutic interventions, but they are analysed in the relationship in order to transform them in resources boosters, hence, in therapeutic factor.
- Developing and testing short term therapeutic plans for the new demands. This is the central point of our work. What we are making reference to is not simply a reduction of the intervention timeframe, but a reconsideration of the culture informing the approach to mental health as it has been developed in the Services. To carry out short-term interventions in our case means assuming that the resources are and will always be limited; the foster care of a patient that often illusorily aims at pursuing deep transformations or at eliminating the symptomatology is a practice to be radically reconsidered.

³ Erikson (1968) proposed the concept of vital cycle focusing on the epigenetic phases of the development. We resort to that term to indicate specific and recurrent moments of a human being’s life strictly related to variable environmental and relational contexts which assume a determining function in providing sense to the individual’s problems.

The work of this group was not easy. Keeping steady the interest for the clinical meeting, place for discussion and mutual enrichment, was the most relevant problem. Another significant hindrance was the tendency to exhaust the discussion of the clinical cases in the mere expression of what came to the single professional's mind, which indicated the difficulty to confer an organized form to the emerging reflections. On the other hand, the absence of a methodology prevented the possibility to delve into the topics and develop them. These aspects appear indicative of how complex it is to activate the planning and organizational dimension and keep them alive among the mental health professionals, as the mirror image to what happens in the relationship between the Service and the patient. The absence of planning in the clinical meeting mirrors the lacking organizational dimension in the relationship with the patient.

The experience of this team, for reasons impossible to analyse here, failed to integrate with the remainder of the Service as the difficulty of internal communication – typical of Italian Mental Health Centers – prevailed in the end.

Short-Term Psychotherapeutic Interventions

In Mental Health Departments short-term interventions has often been thought of to face the so called “common emotional disorders” area (Goldberg & Huxley, 1992), which represents a relevant percentage – ranging from 70% to 80% – of the demands to Mental Health Centers. Born to highlight the demands concerning frequent symptomatology like anxiety and depression, the definition belongs in all respects to the psychiatric classification. Actually the demands included in this typology should deserve a more complex analysis. Accordingly with the thesis of this work, we think it is more interesting to specify them as problems inherent relational contexts rather than as symptomatology. These demands create a quick saturation in the Service causing a crisis in the organizational structure. The operators may think that the mandate does not allow any limit to the patients. The latter can be perceived as potentially invading. The models of intervention based on the traditional psychotherapeutic and pharmaceutical techniques result unsuitable if compared to the amount of the demands. The group psychotherapy and the short-term psychotherapy have already been mentioned as examples of the initiatives actuated to face the increasing pressure coming from these demands. Additional scarcely effective procedures activated to face the problem are the following: cooperating with general practitioners (but exclusively to delegate them some pharmacological management), selecting demands on the basis of priority (with no definite criteria) or forming long waiting lists. It is interesting to notice that in most of the cases these procedures consist in putting into practice methodologies aiming at illusorily reducing the critical impact of the new demands and scarcely oriented to reconsider the clinical methodological culture around which the Service gets organized.

When psychotherapy is translated in practice in the Mental Health Centers, various difficulties are faced, which make its accomplishment improbable. Here we discuss some of these difficulties as they have been reported in the course of the experience by the professionals of the Service we belong to: the patient, at the end of the planned therapeutic interviews, seemed still to “need” the psychotherapy, or he expressed the feeling of being abandoned and left with his own problems; the difficulties that initially appeared “minor” turned out to be “deeper”, so a more lasting work should have been more convenient; the short-term intervention could not be carried out because the problems were “structural” and too “severe”, or they were anchored to a life history of the patient that was so difficult since the childhood to make few clinical interviews useless. The use of terms like “deep”, “structural”, “severe”, “minor”, etc., is indicative of a medicalized stock language, aiming at pointing out exclusively the intrapsychic traits. All the experiences just reported, but for sporadic cases, usually turn out to be powerful hindrances to the extended viability of the short-term intervention.

When dealing with short-term psychotherapy, we make reference to models conceived by various authors of psychoanalytic background that, in our opinion, are scarcely practicable, as they link the effectiveness of the intervention to specific characteristics that the individual must necessarily

have. In other words, these theories are focused on the patient's compliance to mere criteria of indication; so they do not take into account the problem of building up a model of intervention corresponding to the demands and to the context of the Service. Gabbard (1990) makes a synthesis of the ideas of the main authors who have written on short-term dynamic psychotherapy, thus summing up the criteria of indication; among the most relevant selecting criteria there are: 1) the insight capacity, that is a psychological mentality; 2) high levels of ego functioning; 3) a strong motivation to understand themselves, going beyond the simple symptomatic relief; 4) the capacity to establish deep relationships (above all an initial alliance with the psychotherapist); 5) the capacity to tolerate anxiety. A further point that can not be applied in case of therapy for undetermined period, central for the selection of short-term therapy patients, is the theme of the focus.

In this way an idealized patient is outlined, quite far from the subjects addressing to the Mental Health Centers. For example, the indicator "strong motivation" is meant as a static characteristic attributed to the patient a priori, without any consideration for the relationship with his context and for the relational modality that also the Service will contribute to build up. It's worth to refer to the situations where young people show up little motivated, out of parental pressure, or where young husbands arrive under the wife's threat of separation. In these cases the little motivation can take on significance and be transformed in a resource, provided it is analysed in the context of the relational dynamics parents/son/Service or wife/husband/Service. Conversely, wherever considered as a patient's deficit, the lack of motivation is enhanced.

In conclusion, the crisis produced in the Services by the increase of the demands concerning the common emotional disorders highlights the problem of the inadequate resources while no suitable answer is provided, and the uneasiness diffused among health operators remains. The initiatives actually experimented keep some theoretical-clinical paradigms unchanged and, in our opinion, result in a failure.

Delving into the difficulties described above and into some common elements of the literature on the short-term psychotherapy, we believe we can point out some closely related recurrences: 1) the underlying clinical model is based on an individualistic and intrapsychic psychology; 2) the applied paradigms are linear and built on dichotomous axes such as pathology/health, regression/growth, immaturity/maturity; 3) the implicit aim of the intervention is treatment or the pursuit of changes linked to preconceived contents; 4) limits are experienced as hindrances to the treatment or to the ideal psychotherapy and they should be eliminated.

Some consequences derive from each of the points above mentioned concerning the clinical practice of the short-term intervention and they are, respectively:

1) As to the individualistic/intrapsychic approach: Carli and Paniccia (2003, 2010) state that such an approach lingers mainly on the loss of the individual's internal balance and induces to look for the recurrent problems in the history of the subject, in order to identify the stable characteristics of personality that recur in his/her life. For the construction of a sense and for the formulation of a hypothesis, the subject's current life context is not so relevant, as it is considered as a pretext and triggering factor that lets latent conflicts emerge or that gives rise to the reiteration of the individual's recurring relational patterns. In his book on short-term psychotherapy, Sifneos (1978) affirms that the trigger is often an environmental event producing a sorrowful change in the individual's feelings. Commonly it seems clear that in the recent past the trigger has acted in such a way as to reveal a latent angst: it may start an emotional crisis, it may be the signal of an incipient psychotic episode, or be the last stroke leading to an attempted suicide. The problem is decontextualized and the present is simply the space where the personality traits reiterate. We believe the accomplishment of a short-term intervention unlike whenever the current situation occurring in the patient's life is only regarded as a trigger. We think that an intervention of few clinical interviews can just be conceived focusing on the current situational dynamic in the present context; that dynamic represents the emotional space that confers a meaning and uniqueness to that moment of the individual's life, of his/her vital cycle.

2) The recurrent characteristics of personality, corollary of the intrapsychic approach, are defined within ranges arranged along dichotomous axes, such as pathology/health, immaturity/maturity. The diagnostic system is focused on identifying the subject's recurrent and stable personality traits inserted along those dimensions. Some authors like Kenberg (1984) with the structural diagnosis and Gabbard (1990), who has reformulated the DSM-III-R in a psychodynamic key, have represented the points of reference for this approach. More recently other growingly sophisticated psychodynamic-based diagnostic systems have been developed aiming at identifying with surgical precision a variety of personality aspects, in their turn graded on criteria of greater or slighter pathology. Such traits of personality result so pulverised that we lose their sense (Work Team OPD, 2001; PDM Task Force, 2006). With reference to the short-term psychotherapy, some important authors have proposed selection criteria based not only on the characteristics of personality but also on the kind of psychopathology (Malan, 1979; Davanloo, 1980). The analysis proposed by these authors – grounded on the gradations of severity of the pathology or on the assessment of more or less regressive levels of functioning – leads to consider the short-term intervention a praxis that can be carried out in few cases, since some pathologies can not be “reduced” in few interviews, and it would be unlikely to lead the patient to an acceptable level of health/maturity consistent with that approach.

3) In accordance with the scheme of points 1, 2, the aim pursued by the intervention is treatment intended – in orthopaedic sense – as process of correction of pathologic/immature parts of functioning (Carli, 1987). In a more closely psychiatric-nosographic model, that aim can be the disappearance or reduction of symptoms; in a more elaborated and psychological model, it can be the disappearance or the reduction of relationship patterns intended, sometimes implicitly, as pathologic or primitive (Carli, 2003). In his work aiming at shortening the duration of psycanalytically-oriented psychotherapy, Alexander and colleagues (1946) specifically deals with corrective emotional experience. In that scheme the potential aims of a clinical intervention are categorised in a reductive logic approaching to the logic of “all or nothing”. It is a linear system where one starts from a condition *x* and is supposed to arrive at a condition *y*, where the final result is measured on the standard deviation from the latter. The repetitive and stable emotional patterns within the intrapsychic organization must be modified to make room for alternative, more “mature” ones. As already highlighted in the above points, if the problem is posed in these terms, it is difficult to conceive how a short-term intervention could pursue such a target.

4) The denial of the context also determines the denial of the limits that the same context poses. The lack of resources, typical of services like the Mental Health Centers, is experienced as a hindrance to the pursuit of therapeutic targets established a priori according to the employed technique. This is the way to create a therapeutic relationship that is never accounted for. The relationship with the patient is conceived as a monad that does not need to relate to the context where it is set. If conditions for a two-year long therapy – or for the duration it needs – are not provided, the responsibility lays with the Institution, which does not allow to practice the professional competence appropriately. One may ask what is meant by: “the needed time”. Is it anything the therapist needs? Or anything the patient needs? Is it a need established a priori, on the basis of the applied technique? Is it a feeling where the idea of “need” represents something timeless, without any story or any context, something self-referential without any limits? The therapeutic pair, then, pivots around a collusive fantasy structured on the disavowal of a third party, of limits – basically of reality – in a narcissistic and self-referential dimension. The short-term intervention, in these terms, is experienced as a devalued and second best solution.

We believe that the literature on short-term dynamic psychotherapy has produced a great improvement in the technique, but uniquely within the paradigms described above. In an interesting work, Gilliéron (1997) proposes a hypothesis of short-term psychotherapy in four interviews where great relevance is given to the analysis of the demand, to the chartering of the therapeutic relationship and to the context. Anyway his work – contradictorily in our opinion – remains internal to the paradigm of the duality health/pathology. A group of English psychoanalysts, linked to the Tavistock Clinic, have been carrying on experiences of short consultation with young people for years. Wittenberg (1977) underlines that the aim of the intervention is the emotional growth, but

only as an indirect consequence of the possibility to make sense of the patient's emotions. According to the model inspired by Melania Klein, the focus is on the recognition of the destructive and greedy drives of childhood. The context where the current problem is born, in Klein's opinion, remains mainly a trigger that reactivates impulses and traits linked to childhood.

It is necessary now to illustrate how an intervention in few clinical interviews makes sense in our hypothesis. First of all, so that it can be valid, it is necessary to adopt a theoretic clinical model that envisages objectives distributed in a range of different gradients. The aims of a short-term intervention can not be the same as the one of a long lasting intervention. We have pointed out that if we start from x to arrive at y , the indicator of the objective is constructed as negative, as a deviation from y . The latter is considered as a preconceived and idealized point of reference. In this case, both the patient and the therapist are likely to perceive the result of a short-term intervention as an excessive deviation from y , assuming that the shortness of the intervention does not allow approaching y much closer. Thus the short-term psychological intervention assumes an undervalued connotation if matched with a longer term one and it is perceived as a second best choice, induced by the lack of resources. The farther one stays from the target, the more the intervention is perceived as inadequate.

The potentialities of a short-term intervention appear different if we think of process rather than content objectives. The former even etymologically remind of a continuum while the latter remind of dichotomies like health/disease or growth/regression. Setting process aims (for example the development of appropriate resources to reconsider and integrate the meaning of one's own emotions) implies the possibility to figure out the objective in a dimension of continuous enrichment, a sort of expansion of the field, where unpredictable and unexpected transformations can be possible. In this perspective, a short-term intervention can determine, although within certain limits, a significant development, in so far as it rouses new resources and contributes to enrich the field of the clinic action along a continuum.

Francesco, a man aged 37, turns up at an interview together with his elderly mother whom he lives with. He had recently escaped from home without informing his mother, making himself scarce. He had been roaming by car, where he slept for few days, with little money and eating little. Soon after he was tracked down and he came back. The escape happened contemporaneously with a difficulty in the management of his personal economy. He has got a share in a small company dealing with cleaning where he has always had a passive role, delegating the management to the shareholders and neglecting the rest. Recently he has donated a small sum to save it from bankrupt but losses have kept on. His mother, whom he lives with, has always disagreed with that job because she feels that the son is being cheated and exploited by the shareholder. Suddenly Francesco vanished. This is a parent-son relationship where Francesco assumes the role of the one who needs protection and surveillance, not by chance they show up together at the Mental Health Center. In the interview he confirms this attitude. Without going too much into details, it can be assumed that the escape represents a way, however confused, to elude the shareholder and his mother's pressure and have experience of an autonomous space; however the escape also expresses the difficulty to organize a realistic response to his current economical and relational problems. In this case a predetermined content objective could be the attainment of a differentiation from his mother and from his shareholder and a greater psychological independence. We should reflect on what this goal means for Francesco, set indicators that trace an enviable separation/individuation path. The latter would represent the ideal point of reference which our intervention would be assessed on. The final result would be estimated as the deviation from that ideal parameter. According to these assumptions, should no significant level of individuation be reached in the end, the short term psychological intervention could be considered a failure. However, in Francesco's case the target of the attainment of a significant capacity of autonomy (intended as a stable characteristic of an intrapsychic structure) can not be achieved in few psychological interviews. On the other hand, thinking of conquering a little more autonomy than before, however possible, would represent a little representative goal. Conversely, changing the viewpoint, a different objective could be pursued: to enrich the field of perspectives through which Francesco can represent his personal experience assuming that in this way resources will be activated and competences will be expanded to encourage new ways of dealing with problems; thus few interviews could open up potentially relevant and unpredictable developments.

The theoretic clinical model we use is founded on the hypothesis that the demand is the expression of a crisis of the balance between the crisis-carrier individual and his relational context.

The demand builds up a new context, which is the context of the therapeutic relationship where the fantasies associated to the crisis display. Our attention is no more focused on a whole of symptoms, least of all on static and reified characteristics of personality⁴ to insert in refined nosographic classifications, for which a treatment – even a short-term therapy – is expected through a ready made technique. On the contrary, the relational vicissitudes in the patient's life are singled out: that particular context in that peculiar moment of his vital cycle. Considered in such a perspective, the individual will no more show pathologies, regressive functioning or dysfunctional relationships, but he/she will show aspects inherent to his/her relational life that raise questions and problems. In a few interview intervention the focus on the relational context and on the current situation is crucial because it allows to point out what has originated the demand and, contemporaneously, the modalities through which the patient tries to face the crisis. The objective of this initial phase is the building up, together with the patient, of a hypothesis on the nature of the problems in the relational context. Along these lines the individual can observe his difficulties according to radically new perspectives.

One could argue that, for the patient, framing the problems that have triggered the demand in a new angle would represent uniquely a focus, a starting point for a therapeutic work requiring further processes, rather than constituting the objective of a short-term intervention. In a certain sense we agree with this objection. No therapeutic planning can be started without understanding the sense of the demand, but in the meantime we believe it reductive to conceive it just as a starting point. In several circumstances, in the wide and varied area of the individuals with common emotional disorders, recognizing oneself in a structure that links the demand to the current life context raises a real surprise effect that quickly activates new resources; the implications originated from these developments can be the theme of the few following interviews. In more than one circumstance such evolutions occur also in apparently more complex contexts, with problems and situations that appear more disabling. In other circumstances, in the course of the following interviews the patients tend to repeat the original modalities to pose the demand; however, analysing in more details, new possible developments open up as much frequently.

We believe that the relevant objective of a short-term intervention should indeed consist of individuating the implications of the demand, the collusive fantasies that originated it and the current life context together with the patient. In each specific situation resources and developments of different grade are activated. No significant change sometimes seems to be detected; anyway, it should be considered that even when no new competences are apparently produced, the patient could retrieve the sense of the relationship with the therapist in a following moment of his/her life, and evoke in him/herself the reading hypothesis of his/her problems, as they had emerged in the clinical interviews.

The clinical concept of resistance, meant as a force opposing the change, implies the fact that in the initial phases a patient and his/her context can not accept a reconsideration introducing new reading perspectives of his/her emotional experiences, since it would be too distressing. The clinical hypothesis linked to the concept of resistance has often been put on probation by experience. Grasso and Cordella (1993) make reference to Weiss' studies, where he assumes an unconscious level of the patient to test the therapist's response and he observes a reduction of anxiety when the consciousness of an emotional experience related to a relational scheme is acquired. In spite of a history going back to the origins of the psychoanalytic theory (Freud, 1895), the notion of resistance appears quite problematic, since it evokes a relational pattern that, as well as the concepts of compliance or cooperation, is associated with the control on the other.

On the whole the developments we have witnessed have appeared surprising even for us. Expectations were far lower than the developments. Our background, particularly the

⁴ This is not to deny the existence of recurrent personality aspects that the individual is inclined to repeat most frequently. We believe that the problem exists in so far as the clinical attention is mainly oriented by such aspects, ignoring the complexity of the contexts and representing them only as spaces where the individual's personality traits display. Conversely, we believe the context a determining element in the construction of the meaning of a given problem.

psychoanalytic background, did not allow us to foresee the transformations we have been matching with. One can object that these are frail and momentary changes, or they are just the so called mechanisms of “escape into recovery”.

Marina, aged 50, was sent by her doctor (general practitioner) because she was depressed. She worked as an administrative employee for a company and the organizational changes in the working place had raised a state of malaise. After a staff reduction her boss' demands had become too heavy for her and she could not oppose just not to lose the image of available and effective person. Moreover she was not satisfied with her son, aged 20, enrolled at university, who did not study. Actually she was very protective with him and she managed many of the matters concerning her son who handed them over to her. Recently she had noticed a change in him. He had become a little stand-offish and he had detached from her.

Her son's attitude had bitterly disappointed her. Marina's expectations did not reconcile with the onset of her son's desire to try out his spaces more widely. A part of her lived her son's natural desire as a wound and a refusal and the consequent intense bitterness did not allow her to explore other interests beyond the maternal one. In the meantime at work she seemed to care about everything, as well as with her son, but she could not keep after the pressing demands reaching her – and encouraged by her – any more. In the relationship with her son as well as with her boss, she felt helpful but it seemed there was no room for her needs and desires. At the same time she expected her son to reciprocate her sacrificial role. Her son's desire for independence was equalized to a betrayal by Marina. A tight discussion about these themes followed, particularly on the confusion between her son's desire for independence and her feeling of being rejected, as well as on the cultural patterns of mother-son relationship. After the debate the lady has felt better and has started to pursue other interests. The relationship with her son and the problems at work have been dealt with in a new way that left her a sense of satisfaction. Angst and depressed mood were rapidly substituted by new perspectives on her life and on her future.

At the third interview she claimed that it seemed strange to feel good after just few interviews, as everybody reports about psychotherapy as a long lasting experience whose results are not appreciated in the short term. She wondered if her wellbeing was not ephemeral, if it was an illusion, she feared that the depression might recur again. After analysing together the issue, we pointed out that this is a doubt deriving from cultural belief more than a doubt concerning her experience. This sketch describes Marina's surprise – reported also in other clinical cases – at a mental reorganization originated by new modalities of perception of one's own problems. Her experience clashes with the commonly shared culture that wants psychotherapy to last long; it clashes with the widespread belief that significant changes can only occur after a long period of time, facing much of the patient's resistance.

Marina's disorientation allows us to understand, on the other hand, how patient and therapist may share and act out a collusive culture founded on expected models that actually prevent the activation of resources and competences since the very beginning. Without trivializing a complex problem, we would like to point out that through the outlined theoretic clinic path, it is possible to activate resources and development since the first interview; so, however extreme it may appear, even a single interview can potentially consist in a value for the patient, even if within well defined limits⁵.

The short term psychological intervention could be set in the wider frame of counselling or be compared to a problem solving technique. The latter, more consistent with the cognitive model, seems to pursue predetermined objectives and to wish a change that comply with the demand rather than analyzing it. Biggio (2005), on the basis of a screening of the existent literature, sums up the use of the concept of counselling in these terms: the counselling, as a matter of fact, appears as an operative practice more than as a discipline. Literature is often concerned with telling what to do rather than providing reference to the theory of the technique. As to the boundaries between this practice and the psychotherapy, it is often stated that the line of demarcation is “very thin” (p. 8). Often psychotherapy is referred to as dealing with people affected by psychopathologies and counselling as caring for “normal” problems; consistently with the reflections here exposed, we think that such a distinction is meaningless since the working object always consists of relational problems.

⁵ Such considerations can not be mistaken for Talmon's proposal for single session psychotherapy (1999), which appears quite confused on the clinical theoretical level although it points out the elevated drop out of patients during the first sessions.

The proposal we have outlined can not be represented as a package of a certain number of interviews meant as a short intervention technique. Setting the number of interviews is important, but it represents a variable element. Instead the relationship between the patient's resources, the resources of his/her context and the resources of the Service is essential. Only within this relationship can the number of interviews and the appropriate intervention be estimated. Usually the duration of the psychotherapy is considered depending on the characteristics of a clinical situation. We believe the issue can be flipped asking ourselves, in that same situation, what the appropriate clinical setting would be when only few interviews can be planned for justifiable reasons. Asking this question radically changes the observation summit of the problem and allows understanding the indissoluble relation between the CSM (Mental Health Center) resources and the problems posed by the demand. The axis moves from the ideal intervention (associated to the self-referential technique carried out without any consideration of the context) to the possible intervention within a contextual frame that defines its resources and its sense.

Sticking to the ideal intervention involves the denial of the limits, which are experienced in terms of impotence and persecution. The real and contextual limits are experienced as interferences that hinder the completion of the ideal intervention. Complaining about the staff shortages is a typical example of a persecutory and claiming attitude which avoids posing the problem of a reorganization of the interventions proportioned to the existing staff. It is implicitly argued that having more staff is a right, regardless of the social context: hence the attempt to objectify the burn-out of the mental health service workers (Stampa, 2010). According to this logic one could suppose a cause-effect relationship between burn-out and restrictions coming from an institution that does not provide what is due⁶.

On the other hand there are patients claiming their right to be "treated or helped" who perceive the offer of few interviews as something unfair. Thus between patient and therapist is generated a collusive fantasy based on feeling persecuted by those who do not provide them what they need or what is due to them. Such a feeling is grounded on the idea that one's own needs/rights do not have to link up nor to match with a third reality, for example the social-economical one. Following that perception, as already stated, the short term intervention assumes the characteristics of a discomfiting and obliged second best alternative. Experienced and practiced in these terms, it is bound to get stuck in a dead end.

Conversely, in the proposed model the temporal limit – introduced in the chartering phase of the therapeutic relationship – can be transformed in a resource as long as it evokes emotional dynamics that, as object of analysis, will represent a clue and will ease the comprehension of the problems connected to the demand.

In our opinion the greatest hindrance to planning short term interventions does not originate from the patient but from powerful collusive fantasies between patient/therapist/Service aiming at denying the third party (the context). They find wide resonance in broader areas and in social cultures that confirm and reinforce them. Here follows a summary of some of the forms that these collusive fantasies may assume:

- The patient proposes in a claiming attitude the "right" to be treated symmetrically to the therapist/Service, that claims the right to be put by the institution in the ideal conditions to operate the psychotherapeutic intervention. The limit originated by the current social, political, economical conditions is ignored.
- Patient/therapist/Service wish to "resolve", "eliminate" or "correct" attitudes and behaviours. Such objectives, in addition to being undesirable, are however hardly attainable in few clinical interviews.
- The patient wishes dependence and the therapist/Service wish to take on, protect and assume the delegation. The short-term intervention would be perceived as equivalent to neglecting the patient who in his/her turn would feel abandoned.
- Patient and therapist organize their relationship in dual and self-referential terms as if the Service did not exist. Limits and shortage of resources are not considered as no product and no

⁶ Considering limits does not mean being uncritical towards economic policies that cut resources across the board. In the absence of a critical analysis of the political choices, calibrating clinical interventions to resources could result in a way to justify and cover up the contradictions of questionable political choices.

assessment impose any liability. In the same way the wider organization of the service is no more related with.

Clinical Cases

Here follows a couple of brief clinical reports aiming at providing a clinical example of the former argumentations. In both cases occurred an interesting evolution of the implied issue. This is not always possible; there were situations – although to a lesser extent – where the evolution was more difficult, so they deserved further analysis.

Clinical Case: Luigi

Luigi applies to the CSM (Mental Health Service) for a clinical interview after his doctor's advice as he is stricken with anxiety, with a diffuse state of uneasiness, with insomnia. He is sick at home and he gets distressed at the thought of getting back to work. He is married and has got two sons aged 10 and 7. During this period he cares about his family with effort as his thoughts are disturbingly absorbed by the problems at work contributory to his current emotional state. Luigi has been responsible for a work team in a small electrical products company for years. Up to some time before the operation system and the organization of this company was marked by a climate of family and friends. The relationship between the company owner and the company employees and between Luigi and his team-mates were neighbourly. They often went out to dinner together. If some reason for conflict arose it was silenced to keep – in Luigi's own words – a climate similar to a good family. Within this frame was born a friendship between the owner of the company and one of the employees. The latter, after some time began to expect a special treatment in the company, namely career facilitations that the owner seemed to promise. For some reason or other, however, this did not happen and the friendly relationship began cracking. The employee felt betrayed and assumed a claiming attitude. He started pointing out the flaws of the work organization above all as far as the rights of the workers were concerned. Other colleagues coalesced around him and organized into a labour union. So now the climate has changed and has become conflictive. Luigi says that in most of their protests these colleagues speciously appeal to quibbles, even if sometimes they raise reasonable issues. The owner has reacted failing to acknowledge the new labour union entity. The clashing climate has heated up and strong pressure has been made on Luigi, who is a sort of foreman, in order to line up with them and join the union. He feels caught in a vise between the owner and these colleagues. He does not want to join the union and he is boycotted through organizational spite by his colleagues, which makes his management difficult. In this context panic attacks and distress have occurred until he could not stand it any more and he has reported sick. While sick at home he is anguished at the thought of getting back to work. He asks for help but he also hints at a possible request for a further certificate of illness.

With reference to the points formerly highlighted as to the cultural models used in the chartering phase of the therapeutic relationship, here follow the possible observation standpoints.

Focusing on the intrapsychic, the context where the demand is born would be read in terms of place represented as the pretext that gives rise to Luigi's inner problems. We could say, for instance, that Luigi seems to show a difficulty in facing conflicting contexts similar to the one currently occurring in his working organization. Faced with this difficulty he sets in motion defences of avoidance, as for example being away from the working place. We would be inclined to check that hypothesis searching for similar conflicting situations in his present and past life, verifying if his way of living and facing them has been equivalent. The working situation would consist, in that frame, in the umpteenth scenery where Luigi's recurrent psychic problems are reproduced. In an approach more strictly connected to the diagnostic medical model, the focus would be set on the symptomatologic characteristics of his anxiety. Luigi's anxiety would be read as a pathologic response that can be causally and deterministically related to variables like the predisposition, the anxiety-inducing familiar milieu, the stressful working context and other.

The attempt to point out Luigi's stable and recurrent personality traits would be the natural issue of a mainly intrapsychic approach. Among the several possible connections, it could be conjectured that the difficulty to face conflicting relational situations is linked to relational models typical of his family of origin, however re-edited by him. It would be possible to find out other consolidated personality traits and psychic structures associated to the difficulty in managing conflicts. That

research would be thoroughly oriented to catch individual aspects and/or stable relational patterns that pay no heed to the context or that invariably occur in certain contexts. In Luigi's case it would not be surprising to notice that the interest in the events referring to the working context would be overshadowed on behalf of a deeper enquiry on the familiar vicissitudes. In the same way it couldn't be excluded that the current events would be put in the shade to give a clear run to events occurred in childhood, in the conviction that the latter mould almost definitively the psychic structures. Anyway, we do not want to hint that the familiar space and the historical background are marginal in Luigi's life, nor that they are not useful to understand his problem. Anyway, if we focus the attention on the intra-psychic aspects, the context where Luigi's demand is born – the working milieu and its intense emotional dynamics characterised by several emotional acting out – would lose sense. The working context would be reduced to mere triggering event for pre-existing intra-psychic problems.

The pursued objective would be consistent with the paradigms just illustrated. If a diagnostic psychiatric-nosographic model were used, the aim would be the reduction or elimination of anxiety considered as a pathologic sign. If the individual psychology paradigm were followed, aiming at pointing out the recurrent intra-psychic dynamics originating Luigi's response, the objective of the intervention would become problematic. Following this hypothesis, the difficulty in facing the conflict would lead back to several other aspects of Luigi's psychic organization. These latter aspects in their turn would be linked to the past experience. The difficulty in the conflicting situations can be associated to Oedipal issues, but also to relational schemes where compliancy – which is in its turn related to separation anxiety – prevails. The field of intervention would widen. The object itself would assume unspecific connotations leading to a sort of re-organization of personality, or to a generic reference to a more evolved psychic structure; or, conversely, it would become very specific: Luigi should get to be able to manage conflicts in an "appropriate" way, consistent with a more mature level of psychic organization. With regards to the differentiation between psychoanalysis and shorter term therapy, Luborsky (1984) makes reference to focal targets of this type, in a basically corrective logic which sets targets to aim at.

Analyzing Luigi's case through the track just illustrated, we can infer that planning a short term intervention considering the CSM (Mental Health Center) limited resources, would appear a hard task. In this model the duration of the therapeutic intervention is anchored to the corrective objective. If it were not achieved, the intervention could not be concluded, unless it is considered a failure. On the other hand, such targets, in addition to being questionable, could not be achieved by means of a few interviews. Moreover, the shift and the space-time dilation of the clinic observation field need a corresponding timing. According to the existing clinical theories, a psychotherapy directed to global transformations of consolidated psychic organizations involves a process that needs prolonged timing. In conclusion, an attempt could be made to carry out a short duration intervention with Luigi, but – as noted several times on the field – it would result in a dead end as soon as the first difficulties in the therapeutic relationship show up. Just for this reason, in our opinion, in the Services they end up discussing a lot about short interventions, actually effecting few of them. In short, choices of refusal or the creation of long waiting lists end up with prevailing whenever dealing with the new demands and the common emotional disorders.

Luigi's case will now be analyzed according to a different perspective. If we extend our observation to the context where the demand originated instead of focusing mainly on the intra-psychic dynamics, we would be able to get relevant aspects. Luigi describes a working context where a great change is going on. Briefly we can assume that until shortly before, that limited size company was organized by cultural models of familistic type: relationships founded on friendship, on the promotion of harmony, on the inclination to deny the differences in hierarchy and in roles, in a sort of undifferentiated equality. In such an organizational culture differences and divergences can be lived as potentially dangerous as they undermine the dominant structure characterized by the fantasy – expressed by Luigi – of being in a family. Everybody matches with a strong sense of belonging built up at the cost of the exclusion of other significant dimensions of the group working organization. The confusion between friendship and professional relationship born between the owner and one of his employees becomes the incident that makes the group's familistic culture

implode. This involves the development of an emotional context characterized by disappointment and claiming anger that broadens to other individuals generating a paranoid climate. Luigi faces a radically new situation. Everybody is forced to match with differences, divergences, conflicts fraught with intense emotion. Acting out prevails and reiterates. The group referring to the employee disappointed by the owner begins to emphasize the dysfunctional aspects of the organization, with particular reference to the workers' rights. A union is constituted, which could represent an opportunity to give dissent an organized form. But the owner opposes to it and does not acknowledge it as a new organizational variable within a process of change. The conflict spreads. Luigi, as well as all of his colleagues, feels within a distressing spiral, difficult for him to manage. The symptoms of anxiety and the avoidance of the working context appear as the expression of anxiety but also as the escape from anxiety. It can be assumed that in this company a set-up that kept the balance has fallen into crisis. It can be supposed that the crisis arrived because of the weakness inherent that type of set-up. It can be argued that it started a change that included elements of development: differences and divergences at this point could be expressed. If that aspect had been understood, the on going change could have been accepted and seen as a new organizational model, where conflicts would have been thought and organized depending on the professional targets. This was not possible because Luigi and the group still had in mind the old ideal model of familistic harmony and could not but interpret the on going movements in the organization as persecutory.

In our opinion the focus on the organizational dynamics of the context where Luigi's problem has developed is crucial to understand the situation. The latter's difficulty in facing conflicts, observed from this standpoint, is not only an individual problem, but it appears to be strictly related to the difficulty of the company's whole organizational system. Luigi is distressingly overcome by it because he is not able, along with the others, to understand what is going on in the work group. Shifting too much the attention on the intra-psychic functioning and neglecting the analysis of the specific context would mean denying a basic element of Luigi's reality. Instead of noticing the recurrences and reiterations of Luigi's experiences throughout his life, we can point out the uniqueness and the dynamism (an on going change) of the reported situation. Our interest can be focused on the dynamics of the crisis and on Luigi's attempt to face it, at first through symptoms of anxiety and defection from work, then through the demand to our Service, advised by his doctor. The demand appears medicalized. His problem is redefined as pathologic and the demand is mainly pharmacologic. In addition he covertly asks us for a back up to the certification of disease to stay away from work. Luigi seems he can not imagine any other solution but staying away from work. In short, we deal with a pre-existing balance (the organizational structure of the work group and Luigi's role in the organization). The balance falls into crisis (emerging conflicts and difficulty in facing them; the ways Luigi interprets his role are questioned). New ways of facing the situation are acted out (symptoms, defection from work, demand to the Service).

The objective of the therapeutic intervention consists, in our opinion, in analyzing together with Luigi, the steps above mentioned so that the dynamics of the events could be observed from a different perspective. The aim is to promote, through the activation of resources and competences, unpredicted developments characterized by new ways of facing on going problems. Luigi poses a demand because he is in a critical stage of his professional life and the objective of a Mental Health Center, compatible with the available resources, can simply be the one that has just been described, without having to think of dealing with all the aspects of his life; this does not exclude the possibility that significant changes can extend and affect other dimensions. The objective we are illustrating appears radically different from the one pursued by the models mentioned above. We have pointed out how they are inspired to the psychology of the individual and of the intra-psychic and directed to corrective aims based on the binomial axes pathology/treatment and immaturity/growth. Conversely, according to our perspective, a "light" intervention consisting in few interviews appears operable and consistent.

Our proposal was accepted with great attention by Luigi and the analysis we carried on with him, retracing the hypothesis illustrated above, produced immediately for him and surprisingly for us a remarkable decrease of anxiety since the first interview. Luigi could attribute a different meaning to

the intense acting out he had experienced. At this point he felt he could understand better a situation that had appeared confused. The working place was no more perceived so threatening as at the moment of the demand. We believe that an intervention mainly focused on intra-psychic aspects (or on relational ones, but uniquely to be brought back to the intra-psychic), or interventions mainly directed to the treatment of symptoms (pharmacologic treatment), would have induced in Luigi the sensation to face a problem which was his only problem. He would have been connoted as ill or inadequate. We believe it legitimate to assume that this could have broadened his distress as it would have made him feel isolated from the context, unable to give not even a social sense to his difficulties, and it would not have allowed him to notice the intimate relationship between his problem and the one inherent the living context he was in.

Clinical Case: Wilma

Wilma, aged 30, shows up together with her husband. She describes herself as depressed, anxious, distressed, irascible, full of anger, as she feels useless. In a fit of wrath in the presence of her husband and of their children aged 8 and 4 she has brandished the knife menacing suicide. Her husband affirms he is at the breaking point. She is still under drug treatment at a private practice psychiatrist without obtaining significant change in her state. The psychiatrist sends her to the Mental Health Center suggesting a psychotherapeutic treatment. Until five years before Wilma had worked as a shop assistant. She had taken temporary leave to care about the children, then she had come back to work but she had found neither the same context nor the same role as before. She had felt undervalued and, also after her husband's advice, had decided to quit the work to devote herself to her family. Later on she regretted leaving work because now she does not feel fulfilled and lives the role of housewife as diminishing. The lack of a job causes a sense of solitude and uselessness in her. In this same period her husband has started a cafeteria together with Wilma's brother. Wilma asked and obtained to work there but she did not succeed in fitting into. There had been some episodes of jealousy expressed by Wilma towards her husband in the working place, with consequent tension in their relationship. Moreover she felt marginal at the bar in the role she had been assigned. A quarrel with her brother, who had criticised her about her way of carrying out her task, resulted in the aggravation of her emotional experience, characterized by feeling of worthlessness, intense anger, depression, apathy and a sense of despair that lead her to have no will to live any more. She stopped working at the bar. After the first two clinical interviews the psychiatrist that sent her calls showing a certain apprehension about the situation, inviting me to pay attention to the serious condition of the patient, who, in the psychiatrist's words, has no control of herself and does not respond to the drug treatment. She invites me to convince Wilma not to come back to work at the bar without making sure that she is really well.

It can be observed that the demand – first from the husband to the psychiatrist, then from the psychiatrist to the Mental Health Center – is thoroughly oriented to control. Wilma generates alarm and havoc. The problem is soon medicalized. The attention is focused on her “pathology”, even defined as severe. The therapy is exclusively pharmacological. The failure of the pharmacological control issues in sending her to the Mental Health Center for psychotherapy. The focus is once more on the individual. The control and the correction of unsuitable attitudes keep on being the implicit objectives of the possible psychotherapy. There is an attempt to control also the psychotherapist, who should dissuade Wilma from getting back to work. The interest is focused on behaviours, never on relationships.

In this situation at least three contexts, which have been almost ignored, are implied: 1) the family; 2) the working environment of the bar, but also the one Wilma left; 3) the relationship which is being developed between the pair husband-wife, the psychiatrist and the Mental Health Center. The issues concerning marginality, inclusion, integration and valorisation appear as crucial for Wilma as well as for the contexts she relates to. Matching with the diffuse culture of the productive organizations, according to which motherhood becomes an obstacle to the company productivity, Wilma feels far less valued than in the past when she gets back to work after a temporary leave. The feeling of marginality comes up again when, after quitting work, she lives the role of housewife as belittling. Once again her role and her involvement at the bar are perceived by her and by the others as hardly relevant. It is possible to assume that such a feeling is the origin of the episodes of jealousy. Wilma reacts to the acute distress of marginalization and to the loss of her sense of worth with intense anger and with requests expressed as peremptory demands to be recognized. Her claims cause havoc in the bar and result in sending her away, which is later experienced as

the umpteenth failure. The tension shifts with more strength to the family in the relationship with her husband and issues in the suicide threat in the presence of the children.

We suppose that the attribution of a pathology, the drug treatment and the proposal of a corrective psychotherapy, with their aim of control, have sharpened Wilma's feeling of isolation and marginalization, making her distress increase dramatically, which leads her to deserve the definition of patient in severe condition. The psychiatrist's intervention, ignoring the relational contexts and focusing on the individual problem, on the personality, on Wilma's pathology, appears as the umpteenth marginalizing response which boost the distress. By sending her to the Mental Health Center, the psychiatrist decides to attempt psychotherapy as a sort of acting out to raise the stake, where control is still the implicit objective. It is easy to imagine the distrust and sense of despair Wilma expresses when she arrives at the Mental Health Center. She is sent as a patient reported in serious condition, excited, with little self control, threatening suicide. A personality disorder or a bipolar disorder can be alleged. Evidently, on the basis of similar assumptions, an intervention of few interviews would result incongruous and inadequate.

Let's try to assume a different perspective. Wilma's case could be read as the expression of an acute crisis that occurs recursively in the various relational contexts (at work, in the family, in the therapeutic relationship). The crisis is activated by new elements (the disappointment for losing her role and professional value after the maternity leave, the failed attempts to find a new role at the cafeteria). The various relational contexts, in their way, hinder Wilma's integration and she is intended to be considered a burden rather than a resource. They reassert her marginality generating a spiral of tension and distress; one illusorily tries to get out of it through fantasies and acting out of control, which – in a vicious circle – stray away from integration and enhance the crisis. A possible objective of an intervention could be the comprehension and the reconstruction, together with Wilma, but also with her husband, of the meaning of those relational dynamics. We believe that this work, aiming at enriching the problematic contexts of other possible meanings, can give her back a role as well as valorise Wilma and her husband's experience rather than emphasizing the pathology. So the therapeutic relationship with Wilma would be structured in opposing trend to the relational contexts where Wilma is invariably going to feel marginal and hardly enhanced. Distress could find a relief and the emotional vicious circles of the various contexts would break up. We believe that proposing a new vision of the problem allows transforming the crisis in an opportunity for a change, a spur towards new further competences which permits an original development of the situations that have generated the loss of the former balance. An intervention of few interviews so conceived and commensurate to these objectives appears plausible and congruous.

In Wilma's case, following the traced path, our attention was focused on the demand of control from the figures next to her as well as on the role she played in that demand. The confrontation with the patient, sometimes also with her husband, did not pivot uniquely on her feelings, but also on the ones of the individuals belonging to the implied contexts. We analysed, for example, the organizational problems of the working places that she experienced in such an oppressive way. At the same time proper attention was paid to the relational dynamics founded on making a victim of herself and on the claim that the others had to understand her or comply to what she wished no matter how she posed herself. We also pointed out the confusing association between the experience of the criticism she had been suffering, sometimes deserved, and the feeling of disesteem with consequent paranoid interpretation of the event. Contemporaneously the capacities she had demonstrated before the on going crisis were recognised (caring about children and about the family management; her professionalism acknowledged and appreciated in the working place before the maternity leave). Wilma demonstrated an unexpected and quick understanding of the themes discussed during the interviews, which was valued as potential resource useful to tackle her emotions and to acknowledge the others'. Basically, new reading keys for the relationship between her and her context were identified and together with her we built up a caring therapeutic context where her experience could be valued. After only two interviews Wilma felt no more angst, she was able to acknowledge her responsibilities in determining specific relational dynamics and she could better understand the relational threads of her living contexts as well. She was able to

notice how her tyrannical way of claiming for acknowledgment got the opposite result. At the same time she could understand that the devaluing and marginalizing attitudes towards her were the result of problematic dynamics and organizational cultures rather than expression of a negative evaluation of her personality. After three interviews she described herself as more self confident, able to face problems in new ways and she felt more acknowledged by her husband. She reconciled with her brother and got back to work in a cooperative climate. The intervention was concluded after five interviews with the possibility to meet again in case new problems occurred.

If a psychotherapy had automatically followed the patient assignment and the psychiatrist demand, the fantasy of control would have been received. Maybe this would have started a therapeutic path aiming at identifying the problematic recurrent areas of Wilma's personality, at reconstructing her personal history in detail, at highlighting the pathologic or more regressive aspects of her psychic functioning. The problem would have been medicalized, ignoring the difficulty in the relationship between Wilma and her living contexts, as well as between Wilma and the implied therapists, wasting any possibility of considering a short-term intervention.

Conclusions

If the demand is medicalized, the intervention is outlined as a path of treatment which inevitably sets preconceived objectives linked to desirable experiences, attitudes, behaviours and relationships. We have seen how achieving this sort of targets in little time is improbable, as well as questionable. Conversely, referring to the paradigms maintained in this work, we are able to configure the Mental Health Center intervention in a different way. In our opinion it can not be interpreted as an all inclusive care of the patients as it happens in most of the cases. We believe it necessary to go beyond a static vision of life (normality/pathology, recurrent traits, etc.). The function of a Mental Health Service can be fulfilled through the analysis of the dynamic situation where the demand originates, in order to give back new meanings to the difficulties experienced in that specific phase of the patient's life, aiming at activating new competences suitable to face the problems. The short-term interventions avoid taking up patients in foster care. Instead of aiming at deep transformations of the personality characteristics, they promote the search for a new balance in a critical moment of the patient's life. These objectives are limited, not radical but sustainable and – at the same time – able to grant effectiveness to the action of a Mental Health Center. The pursuit of such aims is possible provided that great attention is paid to the dynamics of the context where the crisis develops. In addition those objectives, however limited, can prevent worse and chronicizing issues of the crisis. The individual, contemporaneously, has the opportunity to acquire competences useful not only in the on going situation, but also in other circumstances of his/her life. Even in case few clinical interviews do not apparently produce fruitful outcomes, as it sometimes happens, it can not be excluded that they represent an experience that can be retrieved in other moments of one's own existence. It is not uncommon that the patient comes back to the mental health service in a later period of his/her life posing the old problem again but in a different context, or he/she may express a new problem. We believe this should not be interpreted as the failure of the former intervention, but as a hint that the intervention has been perceived as significant. The new demand can express problems related to a phase of the patient's life which are different from the ones originating the former demand. In this sense we believe that the coming back of some patients is consistent with the proposed model. Each time a short-term psychological intervention is concluded the availability to take in new possible demands from the same patient in later moments of his/her life is granted.

Setting short-term interventions more times with the same patients appears consistent with the model and represents a use of resources more effective than resorting to those long lasting interventions where one risks losing the sense of one's own action.

We believe that the proposed set-up, in addition to representing a more effective and more realistic response to the new demands, can also contribute to reformulate the therapeutic objectives of a Mental Health Center in case of more invalidating problems. This is the case of those situations where the acute psychotic crises are associated to contexts which lose the capacity of integration

till then provided. In these circumstances, instead of assuming the delegation, taking the patient in foster care making the therapeutic relationship chronic, it is possible to think of limited and intensive interventions which, with a more efficient use of the resources, mainly face the critical phase easing the recovery of integrative functions. Moreover, after the acute crisis a work of prevention should be required, through the activation of territorial resources to promote the support to the integrative functions in the social and contextual tissue orbiting around the psychotic situation. Thus, even in this important area the limits deriving from resources shortage would be duly considered and useless waste of energies could be avoided.

When objectives are expressed in such terms as “promoting new resources and development”, it is necessary to consider the implied epistemological complexity. These are open objectives that avoid the problematic of the objectives of content, but they may appear vague and prone to different interpretations. In this regard Grasso and Cordella (1993) state that the definition of a methodological objective can not remain a mere statement of principle, but it needs to be operationalized. In order to make the testing of the intervention possible, it is useful to think of viable “indicators” of resources and development. Without these indicators the latter terminology is likely to be very evocative but generic. Can thinking of indicators of development mean inevitably assuming value benchmarks? We believe that the scientific community should pay a greater attention to the problem of testing the interventions because of the complexity of this issue. Otherwise any theoretic clinical model entrusting its validation to the inner coherence of the same model (and ignoring the issue of the indicators) ends up with getting self-referential and with denying the third party.

In the traditional vision, the demands afferent to Mental Health Centers are conceived in terms of diagnostic groups. Therapeutic responses homogeneous as to diagnosis are often wished for as a sort of standardized treatment package for each diagnostic group. We think it would be interesting, on the contrary, a categorization of the demands on the basis of the recurrent situations and of the represented socio-cultural problems. This is the case with marital problems, with the moments of release in the relationship between parents and children, with the loss of role for seniors, with the issues in work, with temporary employment, with immigration and with many other demands often related to the current social problems: in short, situations that can cause moments of crisis of coexistence. In such cases, starting from the analysis of the social culture within which the problem arises, the Mental Health Service could structure its intervention as a short term accompaniment that gives back the individual meanings and competences useful to face the crisis, alternatively to a medicalized and often chronic foster care.

In this work we thought it was important to focus the attention exclusively on the conceptual frame that allows the arrangement of a short-term psychological intervention. We believe, however, that there are other variables of the therapeutic relationship that are as much relevant for the achievement of the objectives of the short-term intervention; but for reasons of space they can not be included in this analysis.

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