

FAMILIES, TEAMS, INSTITUTIONS

Group-dynamic endeavours

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From the seventies there has been a growing interest in understanding the dynamics of the therapeutic teams working in the Mental Health Centers and soon that interest extended to understanding the psychiatric institutions. In USA an strong "administrative" body of knowledge has been developed. In Europe the Tavistock Institute in London developed important training programs for experts in the field with a psychodynamic approach and in France a group of sociologists and psychologists, led by René Kaës, developed an important theoretic framework less known in non-francophone countries. The author wish to summarize these approaches here, providing his personal experience in the management of academic and healthcare institutions in Spain and Switzerland.

Key Words: Family Therapy; "socio-analytical method"; Didactic Communities

Desde los años setenta ha habido un creciente interés en la comprensión de la dinámica de los equipos terapéuticos que trabajan en los centros de salud mental y pronto este interés se ha extendido a la comprensión de las instituciones psiquiátricas. En EE.UU. se ha desarrollado un cuerpo fuerte del conocimiento "administrativo". En Europa, el Instituto Tavistock de Londres ha desarrollado importantes programas de capacitación para los expertos en la materia con un enfoque psicodinámico y en Francia un grupo de sociólogos y psicólogos, dirigido por René Kaës, desarrolló un importante marco teórico menos conocido en los países no francófonos. El autor resume aquí estos enfoques, proporcionando su experiencia personal en la gestión de las instituciones académicas y de asistencia sanitaria en España y Suiza.

Palabras clave: Terapia familiar; "Método socio-analítico"; Comunidades didácticas

Título en castellano: Familias, Equipos, Instituciones. Esfuerzos grupo-dinámicos

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After the Second World War psychoanalysts were forced to try to understand the subconscious of each of their patients in group interviews. In the psychiatric institutions they started to talk about hypotheses explaining the family genesis of the mental disorders, particularly for schizophrenia. In the second phase attempts were started to treat the family of the mentally ill person with a psychoanalytical orientation although they soon saw that there were very few changes which were possible with that model in the functioning of the family system. In 1963, after President Kennedy's Community Mental Health Act, work with families at "psychiatric risk" or with those with "detected patients" amongst their members increased considerably. "Active techniques" were introduced by what were known as "Experientialist therapists".

From the seventies there was growing interest in understanding the dynamics of the therapeutic teams working in the Mental Health Centers and soon that interest extended to understanding the psychiatric institutions. In the USA the most significant attempts came from the world of the academic centers aimed at business administration. In Europe the Tavistock Institute in London developed important training programs for experts in the field with a psychodynamic approach and in France a group of sociologists and psychologists, led by René Kaës (1-4), developed an important theoretic framework less known in non-francophone countries which I wish to summarize here, providing my personal experience in the management of academic(5-8) and healthcare institutions(9, 10) in Spain(11) and Switzerland(5, 12-21).

1. THE DYNAMIC IN FAMILY THERAPY

Family Therapy owes a lot of its concepts to psychoanalytical theory. Freud not only stressed the importance of the family relations on the formation of the personality but also, on occasions, in fact acted on the family group in order to modify the symptoms of the patients. In several of his cases of hysteria he held repeated interviews with relatives of the patients in order to receive information and try to modify their behavior. He treated Dora (1895) in the context of a peculiar family situation and sometimes included her father in the interviews. The case of Hans (1909) can be considered as one of the clearest precursors to the current family therapies, because Freud treated the child through interviews with the father. On the other hand, the Kleinian therapists worked with the family figures introjected by the patient like a phantasmatic "internal family".

However, the family therapies later owe a debt to structuralism and the theory of communication (22). The Palo Alto school in California (23) proposed that in schizophrenic

families there is communication characterized by an excess of contradictory or “double bind” messages. Different studies which tried to show this hypothesis gave negative results but the studies by the “communicologists” have provided important details in order to understand families.

The contribution from the General Systems Theory to the subsequent concepts of family therapy are found in the originality of its tenets (24), Salvador Minuchin (25, 26) and Murray Bowen (27, 28) introduced some of the original ideas from the General Systems Theory into family Psychotherapy. Hence they accept the innate goodness of communication, the existence of a fair distribution in the relationships, with flexibility in the interactions between the different subjects. The social life alters the homeostasis of the system producing “outsiders”, maladjustments, illness. They add to this the pathogenic role of some “diachronic” characteristics of communication; that deriving from the existence of family “myths”, “secrets” and “issues”. The detailed study of the family’s “genogram” provides information about the existence of some peculiarities in the ancestors which have been completely ignored by the current members of the family being studied. The theoretical relationship between these “information gaps” and the Freudian individual subconscious is no secret.

The systemic therapist, aimed at producing changes and as such barely concerned about facilitating the understanding of the interactional dynamics, performed actions aimed at shocking the system disregarding the transparency or “ethnicity” of the media (messages loaded with noise, reformulation, prescription of the symptom).

2. THE EVOLUTION OF MENTAL HEALTH SERVICES

Over recent decades, mental health services in the West have developed in three phases (29): the *institutional* period, the era of *alternatives* to hospital, and the *management* period. Looking at these phases, which came to be more or less successively superimposed, enables us to understand the development of care which was, in turn, influenced by technical evolutions in medicine, socio-economic phenomena (as well as changes in management technique, and ideology).

During the *institutional* period of the History of Psychiatry, psychiatric hospitals were the only institutions in existence, and as many patients as necessary were hospitalized for excessive, often indefinite lengths of time. Because of the isolation of users, there was a tendency to hospitalize and marginalize underprivileged minorities. The era of *alternatives* to the hospital phase, with emphasis on the so-called *preventive* phase, inspired by

progressive ideologies orientated toward the positive acquisition of mental health, led to *Community psychiatry* and *de-institutionalization* in the 1970s. The *management* period essentially began in the 1980s, as a result of the need to contain costs, and is ongoing.

Although the philosophy of therapeutic communities has become especially widespread over the last few years in half-way institutions, the hospital-based therapeutic community will remain valid. In fact, the latter combines socio-therapeutic treatment and psychotherapeutic treatment with the advantages of a hospital context; moreover, such an approach has shown itself to be useful in the treatment of borderline personality disorder and the rehabilitation of certain delinquents. More research is needed in order to evaluate its efficacy for other diagnostic groups, but it seems that the intensive approach, permitting therapeutic regression while diminishing anti-therapeutic behavioral regression, can be very appropriate for psychotic patients, who have shown themselves to be resistant to treatment by other means (30). Over the course of the last decades, Ciompi (31, 32) has developed the concept of 'psycho-socio-biological integration of logic to affect' in therapy for schizophrenia—an innovative therapeutic approach that seems to be particularly useful for these patients, in which the style of the environment and the assistance given lend themselves to a relaxation of the emotions.

Access to *quality* therapeutic community treatment will represent, therefore, an important element in furnishing a complete psychiatric service. But it must be noted that there is a need for quality: as shown in several studies (33, 34), the lack of participation or the passiveness of patients is principally linked to certain aspects of the programs, such as ward policy; consequently, we have noted that when the program is good, participation and commitment progress. Thus, it is important to improve therapeutic programs, and the skills of their leaders. A study by Nieminen et al. (30) found that patients who obtained better immediate results, generally stayed 10 to 20 days longer in the hospital than those who did not. For our part (35), over the past 35 years we have developed successfully a certain number of group programs, dubbed 'decaffeinated therapeutic communities' (7, 36) in many psychiatric units, with an orientation towards Community therapy in a dozen different care units (short-stay units in general hospitals, rehabilitation units, day hospitals) in Spain and in Switzerland (15)¹.

True therapeutic communities?

Therapeutic communities have had difficulties in surviving in the medicalized atmosphere wrought by the managed-care strategies that are now prevalent in most Western countries (37, 38). However, this type of approach should be an antidote to the trend

towards managed care. Indeed, patients with serious psychiatric illnesses (incompetence, suicidal tendencies, dependency) who suffer from a feeling of profound insecurity will continue to need long-term, intensive therapy, and we should show some reticence when faced with attempts to reduce or dilute the services we offer (39, 40). A training process that adheres to therapeutic community principles should encourage the growth and differentiation of patients and, as Campling and Haigh(41) warn, avoid the indoctrination and “infantilization” that are typical not only of medical training, but also of psychoanalytical training. As noted above, the hospital-based therapeutic community combining socio-therapeutic treatment and psychotherapeutic treatment with the advantages of a hospital context (37) will remain valid.

Access to *quality* therapeutic community treatment will represent, therefore, an important element in furnishing a complete psychiatric service. But it must be noted that there is a need for quality: as shown in several studies (33, 34), the lack of participation or the passiveness of patients is principally linked to certain aspects of the programs, such as ward policy; consequently, we have noted that when the program is good, participation and commitment progress. Thus, it is important to improve therapeutic programs, and the skills of their leaders.

Short-term units

It used to be generally accepted that short-stay units constituted a totally inadequate setting to undertake psychotherapy and to organize the systems of assistance oriented around the therapeutic community model. Indeed, the patients’ serious symptomatology, the heterogeneity of diagnoses, and the typically short stays result in an extremely fluctuating, variable setting which undermines and can even render impossible the usual psychotherapeutic approaches. In addition, the care required by patients placed in these facilities through a court order, who pose a threat to themselves and to others, necessitates the establishment of some “closed units” and compels staff to act in a sometimes overly authoritarian manner. Obviously, such conditions represent a major obstacle to the establishment of a therapeutic community.

In spite of all this, within the framework of different short-stay units for patients with acute illness (42), it has been possible to show the efficacy of psychotherapy and the value of the introduction of certain characteristic elements of the community therapy philosophy into the organizations themselves. At Bilbao University Hospital (43), a standard group analytic program was created in 1980 in a closed unit with 20 beds receiving between 350-450 patients annually ². The clinical state of these patients is characterized by poor functioning insofar as reality testing is concerned, presenting varying degrees of mental

regression, and a predominance in the thought processes of primal defense mechanisms. The environment became, in these circumstances, an essential support for the mental process, and the "ward atmosphere"(20) constituted therefore an important therapeutic tool³.

The effectiveness of modern medication has led to a more "medical" operation of units, and acute symptoms are controlled most efficiently, pointing to the technical differences between psychiatrists and other professionals. Shorter average hospital stay periods have made it difficult to secure such a "participational" environment among patients. Even though at certain centers such as those mentioned above we have maintained a milieu therapy focus, the programs have become less psychodynamic and less democratic - somewhat "decaffeinated", in fact. This, however, does not mean they are less efficient from the point of view of dynamics, because our experience over the years has in fact shown the negative effects of the caffeine administered by certain lines of psychoanalytic action and "pseudo-democratic" environments. Many people now consume "light" products and drink decaffeinated coffee on medical advice, and this is what we have decided to do at our centers.

Didactic communities

In our experience it has been very important to maintain the group training programs we started organizing 40 years ago for the personnel in Bilbao, Barcelona and Geneva. They constitute a kind of 'didactic communities'(44, 45), assuring, in some way, the maintenance of the therapeutic ideology(46) among the professionals. Interpersonal problems among the members of the staff are also taken up⁴. We adopted the format of the "block" programs, attended by 2.500 interdisciplinary professionals and designed to offer them a «didactic setting» with a « therapeutic community » orientation useful for the units where they worked. We also introduced a training in the use of multifamily groups, following the experiences of García Badaracco (47, 48)⁵.

3. GROUPS, ORGANISATIONS, AND INSTITUTIONS

The point that different mental health units have in common, as is the case for all psychosocial entities (49), is that they are constituted by groups, composed of individuals who get to know each other from day to day, who meet, interact, and find each other in a state of interdependence that is not only functional—their work—but also psychological. Lapassade (1970, cited by Petit and Dubois, 1998), describes three levels in these health care

units: groups (e.g., a mental health team); organizations (e.g., a psychiatric hospital); institutions (e.g., the department in a ministry that defines everything established by the laws on mental health which give the institution its legal force).

Kaës (50) defines the *group* as a set of individuals who interact (e.g., with roles and statutes) and share certain norms in carrying out a task. He believes that every group has a type of relationship that, 'paradoxically, is a non-relationship', a 'non-individualization', which is the matrix or the base of every group, and persists in a variable manner throughout its life. He calls this type of relationship 'syncretic sociability', to differentiate it from 'interaction sociability', and refers to interaction as the figure of a Gestalt on the ground of "syncretic sociability".

The individual is subjected to peer pressure to adopt opinions and behaviors in keeping with the group norms (conformism). But conformism is not always so coercive: the individual can value his belonging to the group and conform to its norms with the aim of achieving a personal objective, such as satisfying his need for affective relationships.

In addition, groups generate a certain "team spirit" that enables the individual to defend himself more efficiently against organizational pressures. Individuals can use the systems of roles and institutionalized norms within the organization to reinforce their defense mechanisms against anxiety.

Group affiliation also provides its members with a certain security, which is consolidated by the fact that its members experience 'together and simultaneously the same process of identity access' (Sainsaulieu, 1977, cited by Petit and Dubois, 1998).

Those espousing the trend towards 'scientific organization of work' believed that organizations function like machinery, whose cogs are perfectly adjusted to one another; however, they ignored the affective factors stemming from the relationships among their members. Contrariwise, the so-called 'human relations' theorists, enriched by the neo-human relations school (McGregor, 1974; Maslow, 1943; Herzberg, 1971, cited by Petit and Dubois(49)) showed that organizations originate a series of satisfactions and dissatisfactions⁶. Work can be a source of personal growth and realization when the organization functions according to the idea of a 'happy family'.

An institution (which can be both a group or an organization) is defined as a set of norms applied in a social system, which define what is and is not legitimate in this system (Mendras, 1979, cited by Petit and Dubois, 1998(49))⁷. Kaës (2000b) points out that the concept of the institution has been employed with a wide variety of meanings, and that he uses it to refer to the set of rules, regulations, and activities grouped around social values

and functions. Although the institution could also be defined as an organization, in the sense of a hierarchical arrangement of the functions that are generally carried out inside a building, an area, or a certain space, he used the word organization, exclusively, with the latter connotation.

According to Kaës, every organization has a tendency to maintain the same structure as the problem that it is trying to solve or for which it was created. 'Thus, he says 'a hospital winds up having, as an organization, the same characteristics as the patients (isolation, sensory deprivation, communication deficits, etc.). Our psychiatric organizations, our therapies, our theories, and our techniques also have the same structures as the phenomena that we are trying to confront. They have become organizations; therefore they carry out the same function of maintaining and controlling: a tendency towards bureaucratization (...) The technical staff or administrative team of a hospital also have a tendency to structure themselves like organizations (...) Jacques has said that institutions serve as a defense against psychotic anxieties. This is however a limited statement, and it would be more accurate to say that institutions and organizations are depositories of "syncretic sociability", or the psychotic part, and that would be a good explanation for their tendency towards bureaucratization and resistance to change'.

3.1. The "socio-analytical method" of studying mental health institutions

When acting as a consultant for a mental health organization, it is indispensable to first diagnoses the organizational systems as a whole, and the subsystems that they comprise (49): the real working groups, the departments or services, particular hierarchy, the top management and mid-level executives, and so on. Specifically, a diagnosis of this kind consists of asking questions about the organization's functioning: How are decisions made? How are objectives and plans drawn up? How do professionals and working groups communicate? What is the state of the relations among groups? How are conflicts solved?.

Using the "socio-analytical method" (Kaës), the consultant lives with the organization as a whole, a 'professional' relationship that excludes any kind of private or privileged link with the organization's members or groups, and imposes on the consultant confidentiality with regard to the outside world, unless there is an explicit agreement with the organizational system regarding the publication of certain results of his research. In addition, the socio-analytical procedure refers to psychoanalytical ideas to clarify certain phenomena: the ambivalence of professionals, who are simultaneously attracted by change and discouraged by the fact of having to change certain behaviors; positive transference, through which the professionals project on the consultant their desire for change; negative

transference, through which they project onto the consultant hidden feelings of hostility—indeed, their resistance to change. Dubost (49) proposed that these resistances constitute defense mechanisms against anxiety which can be analyzed and overcome through a method called *perlaboration or interpretative elaboration* (equivalent to *working through* in psychoanalysis): a consultant with training in group methods calls the group's attention to interpretations that concern facts known by all of them, regarding the nature of the resistance that are obstacles to progress. The consultant, says Kaës (2000a), 'should take advantage of all the opportunities that arise over the course of meetings to clarify "here and now" the meaning of feelings (fear, guilty, mistrust) that provoke changes which are simultaneously perceived as necessary and threatening to the group'.

Psycho-sociological references (49) came out of the work of Jacques (51), based on that of Bion and Lewin (50) (52, 53) who, on the frontier of psychoanalysis and psycho-sociology, studied the development of unconscious processes within small groups. Later, Rapoport, at the Tavistock Institute, with his 'action-research' procedure, tried to apply these concepts to persons who find themselves in problematical situations (Rapoport, 1973, cited by Petit and Dubois, 1998).

3.2. Psychoanalytical references

Kaës (50) pointed out that 'we still do not have the means necessary to establish a psychoanalytical theory of the institution, beginning with the constitution of its object.' Jacques's first reflections on the matter arose in the context of a research project of Britain's first Labour government after World War II. Defining institutions from a socio-analytical viewpoint, Jacques (51) differentiated two concepts: *social structures*, which are the set of roles played by the persons in an executive hierarchy, and the manner in which they are distributed; and 'cultural mechanism', which are the rules, taboos, and habits that form the structure of a given institution (54).

The model of Klein's school considered institutions to be defense mechanisms against primary persecutory and depressive anxiety. The ideas of container-containing (Bion) and the containing function (Kaës) have led to a reflection on the need to find a place (supervision or intervision) in which the anxieties and intra-psychological and inter-subjective conflicts present in the institution can be updated, listened to, and thought out. Anzieu's work on the ego-skin and psychological covers have led to research on group and institutional covers (55).

The psychoanalytical viewpoint also bears in mind the characteristic 'climate' of each institution: its history and structure, the nature and difficulties involved in its principal work, the unconscious infrastructure which organizes satisfaction-seeking relationships (2). In this sense, the 'family' comes up as a constant reference point, a favorite example that even justifies and legitimizes resorting to analysis (56).

Kaës points out that institutions inflict various types of narcissistic wounds on professionals: they must realize that the institution was not made for 'each one of them personally, like Providence'; on the other hand, they must admit that their psychological life is not 'exclusively focused on their personal unconscious (. . .) their unconscious does not belong to them, but rather to the institutions to which they are underpinned and which depend on this underpinning.' However, he adds, 'institutions are not immortal. The order they impose is not immovable, the values they proclaim are contradictory and deny that on which they are based.'

3.3. Institutional Diagnosis

The application of findings on institutional organization to the study of patients' therapeutic settings has notably enriched our understanding of the habitat where mental illness evolves (11).

In 'diagnosing' the organizational situation, it is necessary to study the intragroup and intergroup dynamics. This makes it possible to evaluate the degree of bureaucratization, and the size of the gap between the levels of integration and the levels of "syncretic sociability" (Kaës). Once a general intervention strategy has been established, group dynamics techniques are used to confront organizational problems. Many therapists in psychiatric institutes have the basic abilities to collaborate in understanding the organization itself, after undergoing specific training. However, as Bleger warns (57), mental health professionals should take great care not to transfer the difficulties of psychiatric hospitals to general hospitals, and those of these two to other organizations (e.g. industrial, educational).

3.4. Institutional Pathology

According to Kaës (58), the group psychological apparatus should ideally possess the capacity to articulate the strength and meaning of the interaction among its members, to ensure the existence of a 'symbolization space that shelters, administers, and transforms the meaningless drive elements that immobilize common psychological formations.' Pinel (59)

suggests that the alteration phenomena (*deliaison*) of institutional ties are made manifest by a lack of this group economic regulation, both due to a lack or an excess of investment, and are the result of the lack of this skill, cited by Kaës for group psychic functioning⁸.

Kaës (58) refers to the existence in institutions of 'paranoid anxieties, the fear of the unknown or of a new situation (. . .) the fear occurs in the face of the unknown that each person carries inside in the form of no-person or no-identity (or of syncretic ego) (. . .). It is not only newness that provokes fear, it is also the unknown that exists inside of the known.'

In caring institutions, different defense mechanisms can be seen (hypertrophic memory, rituals) and dysfunctional symptoms (attack against thoughts, exclusion of some professionals, immobilization), which we shall examine below.

Hypertrophic memory

Correale described a phenomenon that other authors (60) had analyzed previously, and which often occurs in institutions, especially when they are entering into advanced phases of their development, in which institutionalisation processes are important. It involves the fact that there are certain events which 'have a tendency to become fixed and almost petrified into a collective heritage of memories, following rigid and hard to modify modalities.'

These are collective memories, almost always of relational events from a distant past, which are always told in the same, repetitive way, as if to prove a hypothesis or affirmation for which they must be the proof. Correale affirms that they are true 'retrospective hallucinations', since these memories present, on the one hand, great vividness and clarify, a form of hyperclarity; but, on the other, they seem to not be susceptible to an evolution or an interpretation different to the ones already incorporated into the memory itself. The fundamental objective of these memories is the *evacuation* (52) of something to free the group, although it may be only partially or incompletely, from its harmful effects.

In this context, we can also consider the ghosts of the 'founding fathers', which Enriquez (61) describes graphically: 'In such settings roams that ghost of the first founders, and of the mythical aura that surrounds them, thus enabling the institution to function. These ghosts have a number of functions: 1) to express that in primordial times, at the origin, there existed a cohesive team, without internal problems, since it was motivated by a consistent project, resulting in the appearance of guilt feelings among new members, who are not able to find themselves worthy of such ancestors; 2) maintain the power of the founders, who are still present in the institution; 3) keep the group from questioning the

initial project, because if it were examined carefully, it would reveal the faults and inconsistencies that it presented from the first, and which are the origin of the current difficulties; 4) promote stories, legends, counter-truths, mad rumours that testify, on the one hand, to the underlying presence of an unbearable primal scene reproduced with dramatic trappings, and on the other, the perpetuation of a series of different "crimes" that were committed silently and which, once evoked, appear laughable as events, but which have served to give a tragic air to the whole of institutional life.'

Pseudo-egalitarianism

Caring institutions (and psychiatric ones even more so) live under the utopia of an 'egalitarian' ideology. Every one of the workers can be a therapist. The idea of 'co-operation among equals' is presented, according to Enriquez(61) as a necessity which is, however, immediately denied: 'every specialist can succumb to the desire of thinking that the patient's progress is due only to the specific technique that he/she uses, and that the action of others is nothing but an obstacle. Jealousy and rivalry are going to come up in everything concerning these techniques, and confirming who is the "owner" of the patient'.

Group rituals

Correale (60) highlights institutions' general tendency to preserve ritual moments and group habits, consecrated over time into true ceremonies. These are habits and behaviors that have become stratified over the course of time, and have often lost their origins in a distant past; they can be interpreted as a 'kind of obsessive pathology of the institution, with regard to its strict needs for preservation and self-preservation'. For example, institutions try to resolve conflicts between professionals by creating group clinical casework sessions, and obligatory team meetings (61); however, the interventions of some professionals (e.g., the psychoanalysts) tend to carry more institutional weight than others (e.g., the teachers); those of the more senior members (the founders) than of newer ones. Finally, the meetings called 'talk about problems' become an empty ritual. 'The professionals talk, but the really important questions are rarely tackled because, if they were, they could originate conflicts that would put everyone's security and identity in danger'.

Pinel (59) points out that the 'many meetings organized in institutions to solve issues or conflict do nothing more than reinforce paranoid or psychologically empty experiences. These meetings, repetitive and sterile, are limited to organizing the next meetings for analysis or regulation; they do not more than reinforce the process of entropy. The only

“advantage” that professionals get out of going to so many meetings is avoiding relating with the patients’.

Attacks against thoughts and immobilization

The professional has an ambivalent relationship with the institution, because he finds himself trapped between the desire to satisfy his own ends, and the renunciation necessary to team functioning. This relationship with the institution mobilizes negative affects, such as hatred, and above all, envy. The professional can find himself suffering from a true ‘psychological thought paralysis’ (59), through which ‘his personal thoughts that stray from the common discourse are attacked and destroyed’.

According to Pinel (59), caring institutions reveal their fragility by the recurrence of dysfunctional episodes that mark the course of their history. These crises can proceed from an excess or a lack of investment (‘institutional usury’), which render the institution unable to carry out ‘its essential functions as a defense system against primitive anxieties. Anxiety, whether dull or massive, spread into every part of the institution’. All of these processes are sources of anxiety for professionals, who fear possible aggressions on the part of the institution against their security and survival. Deroche used the term ‘umbrella myth’ to describe the tendency to evoke some chance event in the history of the institution, such as the omission of a formality due to accident or ignorance, with catastrophic consequences inflated by the imagination. Although the professional is aware that, except for extreme cases, his job is not at risk, the umbrella myth enables him to create a rational basis for a set of precautions and protection rites: multiplication of forms, duplicates, authorizing signatures from hierarchical superiors, references to regulations, and so on.

The exclusion of some professionals

In any case, all of this produces suffering in the professional (59), which becomes manifest in the appearance of scapegoats or episodes involving the ritual sacrifice of a colleague. Pinel points out that ‘the sacrifice can take the form of a clear exclusion, of underhanded manoeuvres that lead a professional to resign (or cause a patient to drop out of treatment), but more often with the appearance of psychological or somatic symptoms in certain persons, who become the symptom-bearers of the whole group.’ Often, envious attacks against the idealized institution or one of its members are seen, which can come from the professionals, the administrators, or the patients. Unconscious alliances are formed which result in perverse actions destroying the most elaborate ties, and creativity (62).

Utilization of patients on the part of professionals

Enriquez (61) points out that the relationship that professionals maintain with their clients is molded according to the relationship that they have with the institution: 'Since they can find themselves trapped by repetition, opaque secrets, guilt and rivalry, then can fall into the temptation of utilizing their patients to express their narcissistic needs, and to solidify a continually threatened identity'. At times they devote themselves only to discussing 'analytical theories, educational practices, legal problems, without mentioning their patients, their specific suffering, and the relationship that the therapeutic team should establish with them'. If by chance the patients are mentioned, it is to usurp their voices, presenting themselves as the patients' spokesmen, since these people, with their anxiety and their violence, have nowhere to express themselves directly in a collective space, where their words would be expected, and heeded.

4. TEAMWORK

One of the basic characteristics of interventions in Community psychiatry is teamwork. A team is 'a small number of persons with complementary skills, committed to a common purpose for whose achievement they consider themselves mutually responsible, under the leadership of one of them' (Arrazola, et al.). The leaders use their power to obtain conformity, proposing incentives to moderate resistance and favoring negotiation to reach the objectives previously agreed upon with the rest of the team's members.

The team thus constituted incorporates all of the potential held by informal relationships and the force of group unity, and makes it possible to carry out many tasks that each member on his own would be unable to do individually. Teamwork provides an opportunity for personal and professional development, because every member contributes his competence while gaining in knowledge and skills. The discrepancies that arise in the group can be used to continue to explore issues in more depth. The relationships among the members of therapeutic teams are complex, and can mobilize anxieties that sometimes cause major dysfunctions (54). The ambivalence in team relationships comes from the primary persecutory and depressive anxieties that are produced within the group.

4.1. The importance of self- knowledge

There are subjective aspects that each professional brings to a relationship (value judgements, mood states) which can influence the relationship with the patient, and which it is indispensable for the professional to control. The relationship with psychiatric patients

produces a certain amount of anxiety, which sets into motion in the professional different neutralization mechanisms that can lead to actions not aimed towards resolving the patients' problems, but rather to defend himself against the patient.⁹

Professionals can also acquire expertise in individual counselling and group and family work, enabling them, the context permitting, to function as therapists. This type of training is particularly important when the professional is operating in units that function under the principles of therapeutic communities, in which there is a certain amount of decentralized decision making, and work is carried out in teams.¹⁰

It is important to clearly differentiate the genuinely psychotherapeutic activities from the rest. Indeed, psychotherapy requires specific training in which a university-level professional, specialized in a clinical field, studies a specific psychotherapeutic curriculum, which includes some kind of personal therapeutic and supervisory experience. Without these prerequisites, it is unethical to subject patients to delicate interventions, which can entail some risk.

Moreover, it is important to remember that, although the functions of the team's different members may become diffused, the working hierarchy must not be called into question, and each profession has specific functions, which should not be neglected.

4.2. The team components as attachment figures

Psychiatric illness threatens the individual's security, and professionals can be temporary *attachment* figures who provide an affective holding environment similar to the maternal function described by Bion (63). Through sympathetic listening, they help the patient to develop the *capacity to think* and to tolerate anxiety, using their own mental processes to hold and digest the patient's projections.

In children (64), different attitudes of *insecure attachment* (avoiding, ambivalent, and disorganized) have been described, which, when they interact with other vulnerability factors, can predispose them to psychiatric disorders (65). Some professionals experienced inadequate attachment in childhood, leading them to have a need for compulsive caring but very reluctant to seek professional help¹¹.

Those who work in the 'caring' professions often, and inevitably, fail in their work with damaged and needy clients. If this failure sparks intolerable guilt and anxiety, these professionals (like infants) may regress to these primitive defenses with the aim of

maintaining their precarious self-esteem, and defend themselves from the retaliation they feel is coming to them for failing to obtain a cure.

In adults, there are three main styles of inadequate attachment (*dismissing, worried, and irresolute*) which can be assessed with semi-structured interviews. When they enter into contact with mental health services, those with a dismissing style may find it difficult to get involved in their treatment; the worriers may feel blocked or ambivalent about the help that is offered to them; the irresolute may have difficulty managing the painful feelings that treatment produces. However, those with childhood antecedents of *secure attachment* show themselves more open in talking about their symptoms, and tend to present better pharmacological compliance.

In psychiatric units, some situations can set off attachment behaviors in patients. They may, for example, feel excessive fear of leaving the hospital, and their symptoms may worsen when the time comes to do so. If one of the unit's professionals leaves, this can also produce, in patients who were attached to him or her, adverse reactions which can manifest themselves in the form of aggression, explosions of violence, or other ways, all inadequate attempts to keep that person from going away.

Many patients with antecedents of having suffered abuse provoke excessive attachment behaviors in professionals. However, hostile reactions from patients may lead professionals to experience intense counter-transferences, and use, for example, inadequate holding measures. If they themselves had been subjected to abuse by their parents or educators, they may have a tendency to physically or sexually abuse their patients in a more or less open or hidden way (66).

Mental institutions themselves can become attachment figures for patients who did not experience a secure attachment in infancy. Attachment to professionals and institutions can sometimes persist for long after the patient has left them.

Professionals should provide patients with a secure base, an affective holding environment able to modulate their anxieties. It is more a matter of *being with* patients more than *doing things to* patients.

4.3. Regression in teams

In seriously ill patients' psychoanalytical treatment process, especially psychotics, the professional first aims to induce a regression which will make it possible to take better care of the patient (67) in order to then, through interaction, enable him to restructure his personality. However, it is well known that in this interaction, psychotic transference, due to

the interplay of projective identifications, produces in the therapist a counter-transference quite independent of his own personality.

Some situations created by different psychotic patients seem to be dominated by what has been termed 'projective counter-identifications' (68). Indeed, the therapist's role is that of receiving the patients' projections, elaborating them, and enabling them to be introjected once they are transformed. However, with psychotics the therapist is often compelled to act counter-transferentially, as if moved by these nuclei deposited by the patient's projective identifications and which acquire, within the therapist, a life of their own, if he is not able to perceive them, elaborate them, and transform them.

The therapeutic team should represent, for the patient, an "alter family", which enables him to have a 'corrective emotional experience' to remedy other experiences that may have been responsible for the origins of his illness. However, there are different difficulties within the therapeutic team, some stemming from reality elements (e.g. workplace stress, professional rivalries), others from projective identifications that the patients have deposited in their therapists. Due to a splitting phenomenon, therapists deposit in their patients all of the sick parts that they reject in themselves. In such a situation of denial, rarely does the team have sufficient flexibility to adapt to patients' varying needs.

As Racamier (69) saw it, the therapeutic team can come to feel dissociated by these projections. The tension in working teams increases, and their members try, at all costs, to look as if they understand each other perfectly, to present themselves as an 'ideal family', a containing environment where patients can grow. This need that the therapeutic team members have to simulate that they function like a happy family can lead them to firmly maintain, as we commented in the previous chapter, an anti-authoritarian, egalitarian ideal in which all of the team components are supposedly equal, denying their obvious differences in professional training and personality. In such situations, it is not infrequent for such pseudo-egalitarianism to tend to spread to patients, who are theoretically considered able to assume the teams' responsibilities, although in practice, and in a hidden way, the therapeutic team acts as if the patients were incapable of doing so. In that case, what arises is, in the words of Sacks and Carpenter (70), a *pseudo-therapeutic community*, which has a great deal to do with Winnicott's concept of the *false self* (71, 72).

Winnicott redefined, in his book *Playing and Reality*(72), the concept of the *good-enough mother*: one who actively adapts to the child's needs, an adaptation that gradually diminishes, according to the child's growing capacity to handle his adaptation failures, and to tolerate the results of frustration.

Layland (71) stressed that one of the good-enough mother's qualities is her capacity to accept that the child has the right to transmit all of his needs, desires, phantasies and feelings to her, which he feels as good or bad, pleasant or unpleasant; but she also needs to not expect her child to deal with the more or less unconscious needs, desires, or feelings of the mother herself, which are inappropriate to the mother-child relationship, and for which she should seek satisfaction elsewhere. The example that Layland gives of this is the child's right to bring to his mother his own depressive feelings, and expect her to help him with them. It is not, however, the child's task to deal with a depressed mother. The good-enough mother, in Layland's terminology, is a 'loving mother'.

Along these same lines, we could call a 'loving therapeutic team' one that is able to take on the patients' needs and avoid making them deal with the team members' own difficulties. However, just as the function of the 'loving mother' is not, according to Winnicott, the only function of a good-enough mother, there are other functions that are demanded of a good-enough team: teaching appropriate reality management, self-care, care for others, and so on, some of which could be ascribed to the functions of a 'good-enough father', who has yet to be described.

The therapeutic team should, in addition, from a utopian viewpoint, try to create an imaginary space, one for pre-consciousness, an 'illusion' in Winnicott's sense of the word -- which is, in reality, the space of creativity and psychoanalysis. However, it is self-evident that none of this is exactly simple.

In 1963, President John F. Kennedy of the United States offered a great deal of funding to psychiatric centers for creating new units inspired by the ideology of community psychiatry. Hundreds of centers of this kind then sprang up like mushrooms all across the country, with the aim of getting their hands on this economic aid. Since the 1970s, I have visited dozens of centers of this kind, in different areas of different countries. The typical image of an activities session in one of these programs could be that of a young mental health worker, trying, with an expression of cheerful enthusiasm but clearly bored inside, to get a few defeated-looking chronic patients to form a band, docilely sawing away at some musical instruments. My feeling, in such situations, is skeptical. Between a costly set-up whose efficiency is merely that of a child-minder, and an exceptionally valuable therapeutic setting, the difference is the existence of a space for hope, and the presence of a "good-enough therapeutic team".

4.4. Rivalries

Since the beginning of the community psychiatry movement, strong tensions and rivalries have arisen among the team members. Within a 'democratic' therapeutic setting that promoted the equality of its personnel (e.g., everyone conducted psychotherapy, everyone was involved in decisions about the patients' future), there were, however, obvious differences in training and status: salaries varied a great deal according to individuals' academic level; physicians continued to be the ones who were legally responsible for treatment, involuntary hospitalization, and reports for legal trials and payment of interventions.

During the 1960s, the development of the Community mental health systems in the USA provoked an overload in the number of professionals, their respective roles became quite diffuse, and everyone was considered a 'therapist', with or without the proper training¹². However, in the mid-1980s, a result of a judicial action on the part of the American Association of Psychologists, psychiatrists could not continue to monopolize the psychotherapeutic treatment of ambulatory patients. Thus, psychiatrists soon found themselves moving over to make room for non-medical therapists (73). In the meantime, the transition had already been made in Europe, without as much trauma.

In this context, major conflicts arose over the psychiatrists' desire to reserve for them the function of psychotherapy, excluding psychologists, social workers, psychiatric nurses, and occupational therapists, whose role in community mental health centers was, in their opinion, becoming too prominent. Enriquez (61) points out that today, in such teams, every professional, from the psychoanalyst to the teacher, plays a therapeutic role, all believing that they have a right to 'function like "influence machines"(74) who try to modify some behaviors of those "assisted", in different and contradictory ways. Some wielded more "influence than others, and even, when getting the patients to talk, try to show the preference that the patients have for them...". The patients experience a contradictory situation, one that drives them insane, and they find themselves immersed in a process of fragmentation, not construction, since they are not supported in their experience by an organizing law, but feeling directly in their psyches and their bodies the violence of the institution's fragmentation, incarnated by its members' rivalry and narcissistic self-affirmation'.

4.5. Changing from an orientation to another

In the process of constituting a community team, or in an attempt to change a team that functions according to a classic model into one using a new model, it is necessary to modify anti-therapeutic attitudes learned from previous roles, and also to create less rigid ideas about each individual role. A fundamental part of this is to attain a common attitude regarding the understanding of psychiatric patients, which will enable the worker to take on new roles, and form more significant relationships within the framework of treatment.

The modification of traditional professional roles to diminish their rigidity tends to meet resistance, especially among the more highly trained professionals, who prefer to work in a setting where their authority is recognized and praised. When the team works under ideal conditions, although the psychiatrist is the one ultimately responsible for diagnosis and prescribing medication, he has no more authority regarding treatment than any other member of the team, since these decisions are made between the team and the patient. However, power problems are often channelled into arguments about theoretical orientation: whether or not medications should be given; whether a behavioral, dynamic, or system approach should be used; individual versus group psychotherapy, and so on.

It is in the practice of psychotherapy where, as we have mentioned earlier, power problems most often arise among team members. There are frequent objections on the part of psychologists and psychiatrists to sharing any of their psychotherapeutic functions with nurses, whom they do not consider adequately trained for these functions. For their part, the nurses sometimes resist taking part in theoretical or supervisory programs, especially if they are directed by the team's most highly trained professionals.

The supervisory group is especially useful when it is directed by a leader from outside of the program, and when it does not become just another institutional ritual.

In any case, perhaps, and just as, for women, there is an ideal age for mothering a baby, therapeutic teams also have their time limits. Everyone knows that a psychotherapist working with psychotics has close theoretical and practical relationships with child psychoanalysis. Often, child psychoanalysts work enthusiastically with children for some years, and then tend to quickly abandon working with them directly and draw back to a more comfortable supervising position. A similar phenomenon can be seen among therapists specialized in psychotics.

The therapeutic team also has a time limit on its capacity for illusion. That is why, in our view, the staff of such units should never be long-term, but rather easily renewable, predominantly by new, young, enthusiast therapists. A young, uncultured mother often

takes much better care of her longed-for baby than a psychology professor does of her own unplanned last-born child.

However, one of the dangers facing dynamic therapy programs not strictly based on evidence of their effectiveness is that they are subject to modifications arising from the medical hierarchy at the institution. Thus, when the leadership changes, certain units have lost some of their freshness in favor of more traditional and less personally engaging biological interventions. This is why the process must be carefully observed so as not to lose sight of the basic concepts of the therapeutic program.

We could say that the instability of the changes suggested above would make teams vulnerable²³. But the vulnerability of community health care mechanisms is precisely, in my view, an unfortunate prerequisite for their success. Just as tolerance of ambivalence and frustration, and acceptance of resistance, are indispensable prerequisites in the personality and education of a psychoanalyst.

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² Se utiliza aquí el sistema Vancouver, por elección del autor.

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NOTAS:

¹ The programs of these units include, as a minimum, a daily medium-sized group bringing together patients and staff and a 'small' group for patients, with a dynamic orientation but with occasional cognitive-behavioural interventions as well as group activities ('group work' in Foulkes's sense).

² Stays lasted, on average, 20 days and the most frequently encountered disorders were schizophrenia and schizophreniform, neurotic and personality disorders, as well as affective and other psychoses.

³ Two types of small groups were organised, in accordance with the patients' level of mental disorganisation. Once or twice a week we organise group art therapy on a voluntary basis. Occupational therapeutic groups were also conducted several times a week. From a clinical point of view, the programme's results had been very positive, enabling us to decrease the dosages of medication required and to create a pleasant atmosphere in the sessions, as well as leading to a drop in the number of incidents (e. g., aggression, suicide attempts, escapees) and level of tension on the part of the therapeutic team.

⁴ From the point of view of the politics involved in the training organization, we had tried to create a "democratic didactic community". However we came to the conclusion that a true democratic functioning is not advisable in this kind of training organization. Of course in the three places where training takes place some rivalries, struggles for power and clinical or theoretical dissensions arose from time to time. They frequently merge with external competitions, criticisms and attacks. The prestige of the history of our small Foundation (OMIE), its lack of economic wealth (avoiding greedy approaches to control its power), and a certain benevolence and altruism deployed by most of their patrons has had till now a healthy homeostatic effect.

⁵ Families take part with patients and professionals in groups made up of 30 to 35 people. The sessions last 90 minutes, and are held on a weekly basis. We try to help patients to find the path that lies between the rational and the irrational and to go beyond it, to the emotional stage. Confronted with the most primal anxieties, the response takes the form of a more intensive investment and greater self-control.

⁶ In an organisation, the individuals, groups, settings, and services that it comprises are articulated in an interdependence that is necessary for meeting the common objective of producing goods and services. Any modification of one element leads to modifications in all the others.

⁷ To sum up the difference between an organisation and an institution, Petit and Dubois (1998) use the example of education, which is, *par excellence*, an institution, i.e., 'a set of ideas, beliefs and rules of conduct proposed to, and frequently imposed on, the individuals of a certain society'. However, a primary school group, a secondary school, a university, a ministry of education, are all organisations, which both rely on the institution of education, while also providing it with a concrete basis of existence.

⁸ To understand these movements of *deliaison* and *reliaison* in institutions, Thom's catastrophe theory (1989) offers an interpretation of the dissociations, in terms of morphological accidents, and the reconstruction of the underlying catastrophic dynamics.

⁹ The professional, due to inexperience or fear of not knowing how to respond appropriately, may maintain rigid or stereotypical attitudes, or project his own problems onto the patient, so that the relationship sometimes acquires an antitherapeutic character. Therefore, it is fundamental for teams and/or their individual components to be offered supervision. Frequently, such supervision leads to a demand for personal psychotherapy on the part of the professional.

¹⁰ The professional should, in such contexts, become more a part of the mental patient's surroundings, be they social, family, or occupational, forming part of the multidisciplinary teams created to deal with these areas.

Indeed, with growing frequency, in these types of units the psychologists, nurses, and social workers lead different types of recreational, occupational, or more specifically psychotherapeutic groups.

¹¹ Normally, having discovered many times that the mother, and later, others survive his attacks, the child learns to have confidence that his love dominates his hate, and that his reparation activities are successful. This reduces his fears of persecution and retaliation by the bad mother whom he has attacked. But when external reality fails to refute the child's anxieties, for example, if the mother dies, or retires, or retaliates, then the depressive anxieties can be too heavy to be borne. The individual then abandons his failed reparation activities, and recurs instead to more primitive paranoid, manic, and obsessive defences.

¹² Psychoanalysis was the favourite psychotherapeutic treatment in the 1960s, and the therapeutic model around which most of psychiatrists' training revolved. In the United States, therapists who were not physicians had no right to practice psychoanalysis, and in Europe the legal situation was similar.

¹³ In our experience, one of the dangers facing dynamic therapy programs not strictly based on evidence of their effectiveness is that they are subject to modifications arising from the medical hierarchy at the institution. Thus, when the leadership changes, the program very likely disappear altogether or are weakened. The same is true of the educational programs described here. When new programs were set up elsewhere and those responsible naturally took charge of running them, various factions appeared within management and each program acquired specific characteristics. Uniformity is not always desirable, but there is a danger that excess diversity could denaturalize the essence of the program.