**A short term group of formation with medical staff who work in oncological wards**

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**The person internal to the hospital who acts as intermediary and guarantor of the experience**

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**Abstract**
This paper is about an experience of a group of formation with doctors and nurses on the theme of cancer that we conducted in the oncological ward of the San Filippo Neri Hospital in collaboration with the Psychiatry Service within that hospital. It lasted three months with a weekly frequency. The group was conducted by the consultant psychiatrist (Dr.S.Bruni) and an external supervisor, a specialist in group psychoanalysis (Dr. S.Marinelli).
We thought it better to privilege the basic and real significance of this experience, rather than use a technical and historical approach, and we have divided the work into two parts.
The first part describes the events of the group from the viewpoint of the external supervisor; the dream is considered as a bi-lateral field of work where doctors of the body and the mind meet up. The second part is from the internal psychiatristís point of view, and examines the sequences in detail bringing the experience in close proximity and has the merit of considering the initial and founding aspects of the group.

**Key words**: group's dynamics, group session, context, medical staff, oncological department

**Part one**
The experience came about thanks to Dr.Ducci, head psychiatrist of the Psychiatry Service at San Filippo Neri, and Dr.S.Bruni, consultant psychiatrist. Thanks also go to Prof. Grassi director of the Oncological Surgery and Emergency Division, A.C.O. San Filippo Neri; we would also like to acknowledge Prof.C.Neri, Professor of Theory and Technique of Group Dynamics, (Faculty of Psychology, La Sapienza, Uni. of Rome), where an annual seminary takes place on the homogeneous group in the medical field; also thanks go to A.R.G.O. Onlus (association for the research on the homogeneous group) for their valuable research.
We hope to be able to repeat this experience periodically to produce in time a significant evolution and to better and further the results.

## Reference models

First we would like to elucidate the course that brought us to write this paper, and in doing so we will briefly refer to theories that helped us in our work; our purpose being to render it as clear and as comprehensible as possible for the reader.

Our main references comprehend Balint, and his experiences with groups of doctors and his idea of listening to their specific position; and the general Bionian tradition, that considers the group as a unit, as a subject of psychic production and thought, and as an organism in evolution, composed of individual subjects different from the whole. (Bion).

It is common knowledge that French psychoanalysis provided a whole series of specific contributions and models on the theme of the formation. These studies include experiences of the analytic psychodrama, and group experiences that utilize an intermediate object (Vacheret); studies on the theme of the group seen as a dream and realization of the prohibited wish, desire to enter the maternal body (Anzieu); the group pluripsychic apparatus and in particular the theme on the unconscious alliance and the suffering from institutional ties, (Kaës).

The model of an experiential group described by Corrao (1995) helps us to enucleate different invariances, and to conceive a pattern of experience and conduction in the formation, in which it is possible to highlight the profound emerging aspects of the group, even in a short time and in a setting where the sessions are less frequent.

In presenting this paper we have also taken into account the research carried out by psychoanalysts who have studied the function of the group in public health services, (Tagliacozzo, Barnà, Bonfiglio). In particular, studies on the institutional field (Correale) and the experiences of a group of health workers within that field. These studies describe how the experience oscillates between the drive to find new answers to the needs that the institutional reality continually produces, and the tendency to confirm the traditions of oneís group-team made up of highly affective resources, ideas and memory. Research on the interaction between the different group-teams in an institutional context (Hinshelwood) was also object of our interest. These and other studies guided our experience and the ideas that derived from it.

## The nature of the experience

Our experience is based above all on the hypothesis that a particular listening, together with a dynamic conduction of groups of medical staff and their experiences in hospital wards, can facilitate and also very rapidly, the emerging of a group culture and a real sense of belonging. Above all there is a need for the creation of a space where similar feelings can be shared regarding treatment, illness and death, feelings that are usually introverted or unheeded to in the daily routine; need for an appropriate context where these feelings can be expressed and are given significance. For instance, from our experience, the sessions were not only full of stories regarding life in the hospital, but elements of general knowledge or other related disciplines and various different sectors regarding social studies, politics, economics were

introduced, and even anthropological, religious and bioethical themes came up. These less direct elements in particular, had a strong value of expressive and metaphoric proximity, and they were seen by the group as inherent to their themes and their elaboration, providing a sphere and an expressive framework to the group. They were particularly useful in providing themes and for revealing the nucleus of thought, memory and affects, that an individual experience would have been able to gather only during the course of a very long analysis. These elements appeared rapidly and were based on a professional and human experience accumulated and shared, or sometimes just based on the urgency of a personal motivation. They were obviously not elaborated in an analytic event given the brief length of the meetings, only nine in all; and the demand was for formation purposes and not for therapeutic help. However these elements were able, either to take shape in a legitimate space just the same, for a brief but very intense experience, or be received in a widened and shared scene, (Chianese), capable of transforming the restrictive limitations of the personal repetition, that is often isolated and seldom listened to.

A medical practitioner today has to face an ever-increasing complex and segmented relationship with his interlocutors. In fact the globalisation of social and medical functions, the growing specialization of scientific, medical, technical and technological knowledge, seem to have emptied the traditional therapeutic relationship of the ìfamilyî doctor. And along with this, the field where he works has become increasingly complex, with increasing demands of coordination, information, sustainment and identity reinforcement, resulting in the risk that all these new needs are not sufficiently expressed or simply levelled off, becoming in the long run for the professional practice, frustrating, obstructing, and being most likely to lose touch with the medical (or paramedical) institution and the hospital. Some sectors, in particular, the ones dealing with serious diseases that require scientific research and advanced medical facilities, attract many new forces for the state of need and hope that these facilities undoubtedly possess, however the staff is subject to extreme tensions. Among all the fields, this is definitely the case in the treatment of cancer.

Many psychological studies and psychoanalytical works regarding interpretation to the formation of cancer and the experiences connected to its onset, have attempted to give a meaning to its pathogenic aetiology, and in particular the phantasmatic organization that lies in its representation, (Chiozza, Merendino, and many other authors). The group function finds room not only in Chiozza's idea of patho-biographies but above all in studies of Bionian orientation, that explore the primitive and collective organization of the mind, which are responsible for the equally undifferentiated events, the soma (somatization) and the mind (psychosis), in a bond that is both reciprocal and reversible. It is well known that these elements that Bion calls ìprotomentalî (*Clinical Seminars*) are stimulated to appear and take form and evolve in the group where their primordial origins and their significant characteristics are represented.

In an experience of sustainment of medical staff, the aspects linked to the ìinterpretationî of the formation of cancer do not represent the principle element of

the elaboration, this remains centred on the function of the doctor and his/her concept of the treatment of the illness and all the difficulties involved. Nevertheless we believe a representation of the illness and the object of the medical treatment, by the person who works with the group of medical staff is very important, even though its kept in the background. The reason for this is, not that a model of psychological comprehension must necessarily be conveyed to the person who cures, but the listening to his/her personal, deontological, and institutional problems must be made very different from the concrete reality of somatic events and their cure, in this way helping to transform the idea of the therapeutic function of the doctor that is usually too technical and too global.
Group work that manages to pinpoint these demands and lets them emerge from the collective experiences and reflections assumes great importance for at least two reasons. First and foremost, it gives the possibility to improve the individual and collective organization of the medical staff and their relationship with the institution. The second regards the possibility of influencing the relationship with the patients helping this relationship to collude less with the unelaborated and too involving aspects linked to the fear of the disease, of the dependence and ultimately the fear of dying.

**The context**

During the preparatory phases to the group, collaborating proved to be extremely difficult between the two coordinators, echoing the difficulties in the field of healing tumours and the demands for formation on behalf of some of the staff. The hypothesis of utilizing an external supervision, by a specialist in the field of group dynamics, helped to broaden and differentiate the competences and also the worries. However this lack of understanding between the psychiatrist and the external supervisor immediately created a field of resonance and elaboration of the anxiety. This anxiety was linked to the ìinternalî hospitalís need to communicate its active, professional and independent practice with a qualified ìexternalî person. It took all the time for the preparatory meetings on one side and the enrolments to the course on the other to be completed, before these two areas (internal and external) were able to produce a trustful sensation and cooperation, mitigating the feelings of fear, threat and devaluation (see Part Two).
We treated these elements as forerunners to the group and as specific qualities of the possibility of founding the experience: the group started to be preconceived (Bion) in the context that generated it, and to exist before its realization, containing the elements that composed it and produced it (Bion). The aspects regarding the demands of organization by the institutional framework were imagined in analogous terms. We began to conceive the setting. The temporal-space of the setting was to be created as a possible mental meeting place for the group and its coordinators. And then there was the setting of the material rules to be established, for instance the physical space, the timetable during the hospital hours and the relationship with the head physicians of the different wards. Even the fees of the external supervisor became an important

issue, as it linked up different territorial units of the hospital with the Psychiatric Service. Ultimately two training psychologists from the Service were to attend the group. The rather laborious preparation in the long run helped to define the different roles and the fields of elaboration of the two coordinators.

**The sessions**

A group of five sessions took place before the Easter holidays and a group of four sessions followed immediately after. During the first phase, it was as if the sessions contained, in a disordered but regular manner, all the elements of a presentation: in other words, it was as if the participants were decorating a room with an appropriate choice of furniture hoping that the quality of their choice would be legitimised. The recurrent theme during the first phase was the problem the staff had in communicating the diagnosis of the illness to the persons concerned and to their relations. This theme appeared on various planes, to begin with it was chaotic and dramatic, and then little by little became more sorted out making it elaborative. This aspect, that contained elements negating the anxiety of death, expressed sensations of fear of contact that was emerging in the group. Would this new scene generated by the group be able to contain and elaborate the fantasies linked to the daily practice of the medical and nursing profession and the elements of aggressiveness, frustration and fragility that are closely associated to its efficiency?

The group attempted to find an answer to why it was reunited by exploring the limitations and the functions of the medical profession; reflecting itself in the presence and the function of the analyst and the psychiatrist that generated it, the group elaborated the negation and the fear. The themes were numerous and multi-faceted, sweeping from the hospital experience to psychological reflections on the relationships with the patients; from appraisal of the differences between the various therapeutic duties to consideration of the institutional relationship and the social-medical context in general.

It seemed that all these exchanges could help to bring about a more fluid and less rigid process and a capacity to speak about secret anxieties. Also a fertile sensation to be able to express and share a phase that promised a professional valorisation, (the group was participating to a course and would receive a certificate of attendance), a just atonement for the suffering from a series of stimuli and greatly amplified mourning at every session.

The group learnt to put a limitation to how much it could tolerate by increasing, especially at the beginning, its active necessities or acting-out. For instance, the number of absences owing to duty, the habit of arriving late, emergency calls, and the initial confidential behaviour among the participants that was only seemingly separated from the medical cases. All this went on oblivious to the group and the coordinators. These elements seemed to make up an area of intermediate relations, that facilitated the possibility of an atmosphere in which it was more important that body and mental functions collaborated, rather than accepting that these functions could be recognised or not, or could be disturbing or be in antithesis. This point has

been described more in depth in the last paragraph that deals with the initial movements and the foundation of the group, and the important function the psychiatry service in the hospital had in promoting this initiative.
The Easter holidays registered a caesura producing a sensitive change; a decisive attenuation of fear came about and a major sense of responsibility set in.
One day, a participant who usually brought an emotive and participative atmosphere to the sessions, by her action of arriving a bit late and putting her stethoscope in the middle of the table, contributed to the passing of the group from a defensive stage to a more trustful one. This action induced a telling and releasing reflection initiating a new phase. A phase in which it was more ëthinkableí the idea of maintaining the professional structure and contemporaneously freely explore problematic and symbolic aspects.
Another participant with a particularly sincere and discreet attitude brought a dream in which the personal content, linked to the experience of her own father and the fear of illness, adhered, but not symmetrically, to her experience of a patient who had become ill during the preparations of his daughterís wedding, (the above-mentioned episode, a crucial moment in the groupís vicissitude, is dealt with at length in Part Two).
A nurse spoke of a patientís fear for her son, and a colleague immediately took up the subject expressing her moving experiences in the ward, reflecting on the alternation of life and death.
A doctor confronted his role of concealing the diagnosis from patients, with his private life as an individual belonging to a family.
Another doctor spoke dramatically of the medical profession and how, like in the wards for terminally-ill patients, it is connected serially to the death apparatus. Shortly after, a young woman announced she became pregnant three months before, tracing a link of cause and effect between the day she became pregnant and a call of leave taking from a dying patient she was particularly fond of.
Each one of these experiences discussed with passion and perspicacity by the group, seemed to indicate a memorable step in the progress of the evolution of its specific culture. The themes of life and death that alternated in the eternity of cycle and regeneration started to become the synthesizing organizers of the fear of fragmentation.
The group seemed to rely on its specific ëmedicalí capacity to comprehend and contain the anxiety that erupted every now and then, and with vigorous and convivial attitude ascribed value to the stories and behaviour connected to familiar situations and competences being close to sensory and corporeal confidences and also close to the extraordinary attainment of learning that the relation with suffering and curing illness produces.
The groupís need, emphasized by the Easter break, to prepare and organise the conclusion to the course, contributed to increasing the awareness and the trust. A very much alive and precious experience was rapidly coming to an end.

However, before the end, the necessity to delegate several confessions and intimate fears emerged, and also the hope that the needs the group had come into contact with, could continue to be received. Expressing itself in this way, the group was probably giving form to its initial fears of attending a ìpsychologicalî course just like the psychiatric patients, and also the fear of having developed an unexpected condition of dependence. However it was able to free itself from this fear through an act of liberation resulting in a capacity to start remembering; at this point the group knew it had matured and was in possession of a transformative and fertile experience.

**The dream of the analyst: body and group**

We enter a group like sleeping people enter a dream ña place where the prohibited wish is situated, and where its illusory and anxious realisation (Anzieu) comes about, because our civilization has separated the primitive world of oneiric imagination from the rational culture. In primitive civilisations the dream is closely linked to the forces of nature of which it is intrinsically part, creating the social culture; in the historic civilisation the exact opposite comes about. The rational thought of modern civilisation intervenes in nature and the dream by ordering, representing and constructing symbolic relations, based on a diverse reciprocity. We can deduce that when rational, moral and scientific thought become too powerful, then the need to recognize, and to feel the contact with mythological origins arises. In the primitive world reality and dreaming together form a dynamic balance in continuous harmony with the universe. In the ancient civilisations of Mesopotamia, Egypt and Greece, the dream is, respectively, a prophet that assures the destiny and the harmonious order of the society along with its values and cohesion; or, the ritual repetition of the myth of the phallic descent into the mother earth, re-appropriating the value of the sensorial body that transmutes into the life or death cycle; or else, the dream is the seat of the projections of human passions and ideals, that become more supportable myths for the human and social mind, and more circumscribed, making interaction possible with the human institutions.

The cult of dreams in the Ancient world has always been the seat of ritualising and mysterious practices, whether prophetic, therapeutic, admonitory or memory functions, was attributed to it; or whether its habitual use could reveal concepts and practices ranging from animistic to theatrical concepts, from religious to ordinary daily life interpretations. Divination has always been a collective art that regards not only the individual but above all the individualís society; not only the personality of the individual but primarily his/her origins; not only the existing conditions of the subject, but more important the multiplicity of the subjectís traditions, being biological, social, cognitive, moral and representational.

The evoking power and mysterious suggestion of the natural place or temple, where a dream can be narrated, or incubated or re-linked to its origins, constitutes an area of social power that is similar to an institution that puts the human being in touch with its divine origins or even the very source of life.

Referring back to Anzieuís idea of human and social needs of contact with the dream, to descend into it like a desire to emerge in a maternal body, and contemporaneously to measure oneself with the anxiety of its interdiction or loss, and the hope to return to life, saving oneself from dismemberment and regressive dissolution, (*group illusion* of Anzieu), we can observe that confronted by the myth and the cult, the ritual apparatus of the psychoanalyst who enters a group appears less potent and that its place in the room with its circle of chairs less evocative.
Secular rooms and houses are no different from ancient and noble castles, they have always been inhabited by their natural occupants and phantasms, and their sensitive walls have always emanated unforeseen forces. Likewise, the clothes that we dress ourselves with, even the most observant and functional clothes of the professional and modern age, contain and convey fantasies, sensations and even a ritual, intense ceremony, capable perhaps of acting as a ìmental skinî (in the Anzieu sense), such that they can perceive external signals creating an osmosis with the signals sent from the internal organs. In this way the preconceptions of the analyst and of the group (Bion) could accumulate on the analystís clothes in the moment they meet. A constant fantasy linked to this conception of the clothes-skin could sustain the value of this meeting and stimulate the flow of exchanges that are connected to it.
In encountering doctors, and in particular doctors regarding the treatment of patients who have little chance of surviving, the analyst envisages a key fantasy that sustains the formation of the group. It is a fantasy that deals with unlocking the secrets of the body in which, (and in the concrete cure of which), patient and doctor have deposited and concentrated the most essential and simplified part of the self, and where the possibility of an active progress faces the inert emptiness of defeat.
The group, full of white coats, stethoscopes and somatic stories, is in reality full of primary passions, delicate fantasies and very willing sentiments to evolve towards capable forms of life, of movement and of expression. To penetrate into the human body into its secrets that make it alive, unstable, ill or destroyed is similar to the eternal emotions of being born, of pairing, of dying and of re-birthing, transforming the infinitive maternal and paternal capacities of the metamorphoses of nature and society that is contained in it, the infinitive descent into fertility and in the death of pairing and of reproduction. To penetrate into the deep body of the soma and the group in pursuit of restoration to health and regeneration, concentrating on the body and the speech of the groupís analyst, facing an enormous dependence in which speech and thought are entrusted to the body and the affects.
The analyst, a woman in her middle age, wore a rather suggestive red sweater with a broad neck-line to the first session of the group. This provocative garment, in contrast with mourning, seemed to attract and assume onto the person who was responsible for guiding the group towards an experience, the production and expression of sentiments linked to the body and correlated to sexuality, not from the point of view of desire and practice, but from its aspiration and formation or its loss and its inaccessibility.

An area was created where there was joy to be participating to a regenerating group presented also by the youthful and attractive psychiatrist. An idea of a vaguely seductive dependence oscillating on the theme of illness, of the confrontation between life and death, between the mind and the body linked one session to the next, enriched by all the sensorial, emotional and corporeal elements through which the reversible and reciprocal aspects of the experience were able to be carried out more directly and with more ease.
After the Easter break, the suggestive red sweater and the series of gold, silver and coloured tops that followed, were replaced by a black sweater with a mink collar.
A strong sensorial bond accompanied the slow and subtle progression of mourning and its elaboration.
In the last session the tearful farewells, and the sensations that had been respectively, experienced, deeply hoped for and ultimately lost, mixed with the active and aggressive attempt to conclude an experience that had sheltered and contained new and diverse elements. The leave-taking remained suspended in a difficult condition.
The group secretly (or consciously?) spotted the analystís fake-leopard skin sandals and didnít waste time in describing a participant, (who brought a dream for the group ñ the Genius Loci of the group (Neri, 1995), like a tiger that embodies the potency of aggressiveness, exceptional speed, and maternal care.
In conclusion, I asked myself, did the group achieve its objective of being a dialogue between conscious and unconscious elements, between corporeal and mental elements, between true and imagined elements, between elements of hate and love, between searching and fear?
Yes, this group of doctors succeeded in doing it.

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## Part two

The second half of the last century saw the growth of a keen interest on the part of psychoanalysts in the study and research of the characteristics and eventual difficulties found in relationships within an institutional environment. This interest opened up fields of research and knowledge on the way team-groups function, especially in organisations providing medical treatment and assistance, thus creating potential for therapeutic intervention in an institutional environment.
The authors (Kaës, Pinel, Tagliacozzo, Bonfiglio, Barnà and Correale) agree that a specific vision is necessary involving institutional relationships. Kaes, for example, introduces the concept of the pathology of inter-subjective relationships, not as a derivative of individual properties but as a cause of group psychopathology, as a specific disorder of institutional relationships.
In particular, most of the authors underline the need for group mental space, Correale's "institutional field", Kaës's "meta-interpretative function of the preconscious" (particularly set in motion by the group), the need for specific acceptance, treatment and knowledge of the pathology of institutional groups.
In particular, J.P. Pinel's concept of a "third function" in any treatment undertaken in such organised groups, underlines how no therapeutic actions directed toward the institution can be sustained solely by whoever initiates such actions. Pinel affirms that: "Without the creation of mechanisms which lead to the containment and recall of elements transmitted during institutional sessions, a kind of intoxication of the psychic apparatus of the supervisors of the intervention will occur", indicating therefore that in his experience the presence of a "joint supervisor" of the intervention and of an institutional reference group to which he/she could be associated is extremely useful..
In this work to which I am referring, the presence of two "supervisors" was extremely useful. In particular, I would like to consider the experience of the function that I carried out within the group: i.e. the link between the institutionalised priorities of the medical profession and the more visibly psychoanalytic function of the supervisor.

In obtaining the consent of my colleagues in the hospital to the initiative my immediate concern was, in fact, to explain to them that it was a rather unique proposal in which sessions did not envisage lessons or reports by the teachers, but would provide an occasion for participants to freely report on their own experiences related to the chosen topic, assisted by an external supervisor, Dr. Marinelli, a specialist in group dynamics. I also explained that I too would be guaranteeing the organisation and the progress of the experience, both in the period prior to the formation of the group and by my presence alongside the supervisor.
It was the first time a psychological formation initiative was offered to the medical staff from the institution itself and held in the institutional environment.
It was this "pioneering" aspect; I believe, that was responsible for the length of time involved in planning this initiative, despite the fact that it was scheduled to take place for a delimited time period (three months of weekly sessions). During this period, the transference of the future participants and the counter-transference of the supervisors, helped to slowly establish a mental space, prior to the commencement of the group, in which the subject matters with which the group would have to deal in its work were animatedly brought forth.
Moreover this bipartite characteristic of supervision certainly encouraged the unfolding and distribution of transference dynamics, thus facilitating and accelerating their "mentalization" in spite of the limited time period and the institutional context.
In particular, I was and still am, a psychiatrist working in the hospital with my colleagues who have known me for over ten years. In recent years I have been particularly involved in the work of psychiatric and psychological counselling in the wards, and have gradually become a recognisable reference point in that area of intervention.

During preliminary contacts with my colleagues for the formation of the group, this enabled me to develop a special sensitivity towards, and identification with an important area of need, the difficulties and frustration connected with the medical profession. The doctor is asked, in fact, often idealistically, to have the ability to contain psychic and physical suffering as well as demonstrating professional efficiency and the capacity to provide solutions.
Likewise, in our introductory chats, my colleagues asked to be listened to, but also demanded answers, indications and protocols. They had to face the reality of deaths every day and lives to save.
They showed a need for dependence and help, and attachment to dependence and to the hypothetical conversations of psychology and psychoanalysis, calling into play in counter-transference my double role as a doctor and psychiatrist within the institution and of joint-therapist together with the supervisor.
This function of guarantor of medical professionalism provoked states of great anxiety in me stimulating me to communicate to the other supervisor the particular state of need of the group, with which I myself was partly involved owing to the

forcefulness with which it was being put forward. It also encouraged me to activate a modality of conduction, that would not be experienced in a persecutory manner. For example, I felt I had to express the fear which paradoxically the group, still in early stages of formation, was developing in regard to being "listened to" adequately which would have allowed a real contact with its need. It worried me lest the group should feel neglected, perceiving the therapist to be too distant and restrained.
There was a long period of about two months before the start of the group, during which the supervisor and I encountered a series of reciprocal difficulties and misunderstandings despite the fact that we had had a particularly affective relationship for quite a while. She felt the mental setting she was preparing was threatened by my attitude, whereas I felt the risk that her remoteness from the reality would jeopardise what she was about to come into contact with. We even came to the conclusion that it would be impossible to start the group, and I believe that our personal and private relationship, which had developed previously was extremely useful. It is unnecessary to mention the function that this movement of postponements had in reciprocally containing both our anxieties, finally leading to introducing an experience of major contact in an environment that was so strongly medical, such as the hospital organization.
When the group began, the great quantity of acting out, confusion, need for help, fear and dependence attachment was immediately obvious.
The first sessions were characterised, above all, by late arrivals, mobile phones and tracers, which rang continually, participants leaving the group for priorities and urgent calls connected with their profession, but also the impelling need to communicate themes, problems and expectations.
At the second session, the group was already able to generate, in a more organised and precise manner, a first movement towards self-affirmation expressed in the form of a provocation aimed at me. A woman doctor, the only one who had also had cancer, asked me in an extremely aggressive way how I would have behaved with a given patient.
The force of her challenge left me paralysed for the entire session. I couldn't reply as I would have done in my role as a psychiatric consultant because the new group context had changed our reciprocal positions, nor was I able to formulate a reply as joint-supervisor within the established setting, and I remained silent.
I succeeded in answering my colleague only several sessions later when the group of participants was capable of observing the intra and inter-relational dynamics with their patients in a more internal manner.

The force of that provocation, however, had, on the other hand, the ability to encourage reflection in us supervisors and helped us to clarify a de-fusion of our functions, a greater distinction of roles and related meanings, enabling us to achieve an improved and more extended distribution of transference valences. The group was supervised by Dr. Marinelli, the only one of the two from outside the institution and who, for the group, had the function of referent, a neutral participant, whereas I felt I

should have partly shared the responsibility for the progress of the experience of my colleagues and partly their passiveness and dependence towards the supervisor.
At the next session, I sat far away from her, on the opposite side of the circle, leaving her to lead the group. At the same time I felt free to fulfil that function of "go-between", or of sherpa to use Kaes's expression, which had been mine from the inception in this experience.
This enabled the group to experience the presence of the supervisors in a less idealised and persecutory manner. In particular, it was possible for it to safeguard the most decidedly psychoanalytic function of one of them. It was also easier for the group to receive feelings confirming its self-esteem, the restitution of dignity to its aggressive valences of attachment to the relationship, and the experience of impotence inherent in its position as healers by identification with the other supervisor.
I, like the others, was a hospital doctor. Like them I was submerged in the confusion of a difficult task. The hospital doctor, in contrast to "family" doctors or those operating in community services, is often required to take on a frustrating and at times impossible task, that of dealing with the most extreme and acute cases, where the involvement of death is closer.
For the entire first part of the group's existence - it too had a dual articulation, divided in half by the Easter holidays - my role was that of making the acting out more tolerable, their stories less concrete and serialised, and intervening to recapture them in a manner more closely linked to the emotive movement which was produced and to deliver them almost pre-digested, as proto-thoughts, to the mind of the supervisor.
In one of the last sessions, for example, a doctor manifested his expulsive anger towards a process of greater and more intimate vicinity to suffering, describing a foreign clinic where patients went to die after they had been given their diagnosis and the prognosis on their life expectancy, a place where they waited for death without clogging up the hospitals.
Perceiving in this intervention his difficulty to make contact, I said to my colleague, using the known and shareable experiences of all the medical staff present, that hospital life was extremely tiring, it was tiring to be immersed every day in a place of suffering, to continually hear requests and be available. This allowed the group leader to link, in a less distant manner, a more precise and profound intervention on the state of the group and to indicate how it was in reality expressing feelings of fear and contagion in respect to pain and death.
Likewise, it seemed to me useful to transform some of the supervisor's actions in a way which was closer to the every day reality of hospital life, by being a bit more active and visibly participative. I did this by filling scarcely tolerable silences, livening up areas of depression which were less approachable in an institutional context and above all by giving more dignity to the need for dependence within a group of professionals whose institutional duties were more those of giving than receiving, to look after rather than being looked after.

This more acceptable management of the movements of dependence and attack of the relationships within the group, also due to this continuous function of go-between the world of emotions and that of medical priorities, which revealed themselves first in terms of protest, then conflict and lastly, for some aspects, of integration, corresponded to and favoured a swifter evolvement of the principal theme, which this group of healers of terminally-ill patients seemed to us to have expressed.
The group members narrated, in a way which reflected their patients' experiences and in a more internalised way as the group experience progressed, of experiences of corporal entrapment evoked by cancer and the anxiety related to the experience of sequestered and confused energies unable be utilised.
It is not the aim of this report to provide an analytic reading of the sequences, but I consider it important that some synthetic elements, some points should be underlined to help the understanding of how dual leadership in the professional and institutional environment allowed a swifter organisation of the group into a working structure.
Only one dream was described and this was about half way through the experience and was recounted by the same participant who had launched the initial provocation I mentioned earlier.

The dream marked an important evolutionary passage and a turning point in the group, which had dedicated itself until then to discussing the restrictive, depersonalised, serialised and repetitive atmosphere of hospital life, as well as the suffering, with each session adding deaths to the tales of the week, impotence and confusion in group members' professional behaviour, at times subject to the laws of necessity at others to human compassion.
My colleague dreamed of reality, the same scene which actually happened in her ward the day after her dream, in a pause of the night shift. The dream was: "After a night on duty, the next morning she met one of her cancer patients in the corridor. This patient asked her to help him to live at least until the marriage of his daughter which was to take place shortly afterwards." After this account, she was moved to tears mentioning her own father's illness, thus revealing her identification with the daughter of the oedipal couple present in the dream, and she was amazed at the strange relationship between dream and reality.
It appeared useful also to us to reflect on this truly valuable data. They indicated in fact an element of hyper-concreteness and the emotional drama experienced by doctors with their cancer patients. In the dream there were several condensed elements. The lack of distinction between fantasy and reality, the hyper-concreteness of the growth of the tumour connected with the attempts at flight from inseparability, parricide fantasies.

In the dream, as in reality, the father dying of cancer is asking to live until, in his eyes, his daughter dies by leaving him on her marriage, and the daughter-dreamer fantasises on the death of her father with the birth of her new life.

But this dream indicated the potential for internalising and accepting the need and aggressiveness connected with dependence. The woman doctor, by identifying herself with the daughter who was about to be married, was demonstrating both her need for the presence of her father at this stage of her life's journey together with a parricide fantasy connected with the development of her adult identity.
This newly acquired setting of greater acceptance of experiences of dependency enabled another member who had more faith in the group and in its existence, to confess during the next session her three-month old pregnancy, considering she had by now overcome the biological risk period of miscarriage, but also perhaps the risk that the group itself could be "miscarriaged" and abandoned, through failing to contain such perturbing dynamics.
This group member emphasised that the way this baby had been conceived after the affectionate farewell of one of her patients before dying had had a special meaning for her. On receiving a telephone call from her dead patient's relatives, my colleague said she had understood that the death of her patient and the conception of her child had occurred with a strange coincidence.
The group continued to contribute to expand and discuss for the entire session emotions of joy, envy but also worry, fear and horror, describing fantasies both of resurrection from death and generous delivery by figures with parental connotations, functions of procreation such as maternity, but also fears that a "monster" had been conceived or that the mother might, along with the growth of the foetus, conceived in fact during the period the group was being formed, conceive the growth of a tumour.
By dealing with similar vertiginous fantasies, the group achieved a slow and painful unconscious journey with regard to the central event which had provoked it, around that difficult watershed found between states of indistinctness and inseparability, fantasies of corporal entrapment and horror at the development of madness or of a malignant and cancerous pregnancy, and the need to be looked after, for understanding, and above all the need of separateness in its desire to liberate and experience creative and procreative energies.

I believe an institutional, but not therapeutic experience, limited in time, with two supervisors, facilitated the projection and individuation of splitting elements, even very remote ones. By differentiating between the supervisors, this group of doctors was more readily able to manage their dependence related to aggressiveness, and protect that initial good and generous process of ability for care and contact, with the need of which they certainly showed they were aware of having.

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