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Group Psychoanalysis: An account of 50 years of work

THE HOMOGENEOUS GROUP IN THE TREATMENT OF EATING DISORDERS
Interview with Flaminia Cordeschi

Edited by ***Gian Domenico Mosco***

GDM: What role do monosymptomatic groups play in the treatment of Eating Disorders?

FC: The psychoanalytically based monosymptomatic group has been used for some time in the treatment of DCA, offering a specific framework to the conflict between the subject's identity and the bond with the other. The identity of patients with DCA presents a disharmonic relationship between body and mind that manifests itself mainly in an experience of inadequacy and in recourse to the defence mechanism of body-mind dissociation. This type of functioning is reflected in the relationship with the other, which takes on aspects that threaten the subject's narcissistic balance.
Sharing and emotional exchange in the group produce a containing effect that is useful for the transformation of distressing and persecutory experiences.

The possibility, through new contents, of expanding sensorial and bodily perceptions also allows one to gradually contact the patient's mute or obscured aspects, the emptiness, his or her traumatic areas often communicated through acting out and, thanks to the analyst's interventions, to put them in communication with psychic aspects by creating links between the real and symbolic dimensions, to collectively digest them, to progressively represent them in the group's somato-psychic space.
I therefore think that therapeutic groups of this kind can be a particularly useful tool for accommodating the painful interweaving of individual, contextual and social factors that characterises DCA and for capturing over time the transformations of this pathology on a collective level.

GDM: How important is the fact that all patients have an eating disorder?

FC: I would say it is fundamental. Homogeneous monosymptomatic groups originate both in the institutional hospital setting to cope with particularly disabling organic or psychiatric illnesses, and as part of self-mutual-help initiatives that have developed with the aim of mutual support between patients united by the same condition of suffering.
In the field of eating disorders - I would say especially in the field of private social work - the two dimensions have been brought together in order to give emphasis and recognition to these pathologies and address them in depth through teams of professionals who share, together with patients and their families, values and ways of being together.

GDM: What are the characteristics of homogeneous groups in the field of DCA?

FC: Like all homogeneous groups, DCA groups offer the possibility of specific containment, rapid belonging, sense of trust and security, construction of shared images and group self-representation. The homogeneous group is able to activate spontaneous, but at the same time specialised therapeutic factors.
I would like to point out that in order to realise a homogeneous dimension, it is not enough to be monosymptomatic alone, but it is necessary to identify other common elements among the group members (e.g. age, treatment phase, previous experiences) so as to activate a sense of belonging and the right to participate.
Important in the field of DCA is the dual evolutionary/destructive register of the symptom experienced as a search for a 'solution' to one's psychological discomfort, especially in moments of life that require a difficult reorganisation of identity. Although the symptom involves an attack on the real body, it is experienced as a psychic survival strategy to be able to

participate in life, to counteract the precarious sense of self, to manage the experience of vulnerability.
Another aspect to be noted, but of DCA patients more than of groups, is that they do not usually present themselves with a demand for treatment of the symptom, since they experience it, as I said, as self-care. Instead, they ask to be able to maintain the symptom in a moderated, weakened or modified way until the body-mind dis-ease is sufficiently reduced.

GDM: What role does mirroring play among patients?

FC: Collective identification in pathology is the first way of being together and represents a passing identity based on the ideal of thinness used to compensate for the perception of inner inadequacy. At the same time, however, an anticipatory fantasy of an authentic inner identity that has not yet found form and meaning is also shared.
The symptom is initially experienced predominantly as a 'concrete fact' that can only be brought into its pervasiveness in the group, then thanks to the possibility of also being reflected in the differences of the others it becomes, through therapeutic work, more and more also a new psychological fact.

GDM: In the case of DCA, group treatment is therefore an important alternative to individual psychoanalytic treatment. When is it preferred?

FC: I would not speak of preference but of priority, evaluated for each individual patient and at different moments of the pathway. For a significant part of patients with DCA, starting treatment in a context of "like among like" is felt as a more protected dimension compared to the dual therapeutic relationship, in which exclusivity and intensity of investment can expose the patient to traumatic repetitions and consequent ruptures of the setting. In the group this risk is reduced and being less exclusive it becomes easier to loosen the rigid alternation between fusionality and detachment to access an intermediate relational distance.

GDM: The group, however, is not the best treatment modality for everyone

FC: Indeed it is. Some patients feel the need to have a specific individual focused attention, an intimate and exclusive space.
However, I would like to underline that the group is often preparatory to individual work and at other times it can accompany the individual pathway at an advanced stage, acting as a third element to facilitate the difficult process of separation-individuation in the dual relationship. In some cases the group course may also follow individual work in socially isolated patients,

as a 'gymnasium' to test the changes made and prepare for a gradual reintegration into the 'outside' world.
In short, it depends on the patient.

GDM: What advantages, if any, does treatment in an institution specialising in the treatment of eating disorders provide?

FC: Let me first clarify what I mean by 'institution', which is not a social body or a juridically organised body, but a regulated and organised space in which the patient and the group fit in, allowing the sharing of discomfort between patients and their families and at the same time the dialogue between different professionals. Roles, skills, and the management of tasks that each operator has to perform are part of a collective dimension of values, emotions, ideas and ways of being together that make the team a small community capable of providing an integrated intervention understood as a shared collective pathway.
An institution of this kind amplifies the function of the symptom by intercepting the collective need to be recognised as existing through the DCA and allows the emphasis to be placed on the recognition of the symptom as such, to process its encrypted contents.

GDM: Can we elaborate on the composition and role of the team?

FC: The reception of these patients requires a multidisciplinary team made up of psychoanalysts, nutritionists, endocrinologists and psychiatrists capable of developing a common 'integrated' thinking, i.e. a tuning of the group to accommodate mental states that are still not integrated.
The role and position of the analyst and other caregivers in the team involves multiple listening that can lead to recognising from time to time the emerging priority/urgency in the mental field and pointing the way to the next steps, aimed primarily at fostering mind-body integration in the patient, sharing the patient's management difficulties on a case-by-case basis.
The central function of the therapist is to be present as an integrating object, to foster transference onto the body, to tolerate investment and oppositionality, to carry out a continuous re-signification of internal states and mental state transitions.
The group offers a "multiple place" that allows a new aggregation of the elements of the psychological field and enables aspects that may appear incompatible for an individual mind even if trained to dialogue with one's inner groupness to be held together.

GDM: Back to the institution

FC: The process that involves patients presents aspects that are isomorphic to the one that goes through the team that is prepared to listen to the data that emerge, recording the splits, projections and projective identifications of the patient and family members that can be activated by the same multidisciplinary field.
Working in a DCA institutional context allows one to experience how the group mind is particularly suited to grasp the complexity of these disorders.

GDM: Are there private non-profit structures in the field of DCA?

FC: Yes. The private social sector is present throughout the country with various non-profit associations. Some are part of the third sector, others, especially the smallest ones, have chosen not to enrol in the Single National Register of the Third Sector, as they do not yet feel able to adhere to a model of association that seems to me to be very rigid. However, they all operate with similar objectives and modalities and try to compensate for the lack of availability of public centres.

GDM: I would like to remind you that Article 118, paragraph 4, of our Constitution calls on citizens to take personal responsibility for activities in the interest of the community, but also on the State and local authorities to favour it

FC: Public intervention is essential, the specialised centres of ASL and hospitals are fundamental, the role of schools in prevention is important. But it is just as important, especially in times of limited economic resources, to offer assistance that also includes and encourages the private sector. This is only partially the case today. On the other hand, the phases of treatment are different and can include hospitalisation, residential intervention, day hospital, as well as long-term psychotherapy, nutritional intervention and school or work reintegration in contexts closer to the patient's usual life. There is room for ever closer public-private dialogue and collaboration in the interest of patients, which still seems insufficient today.

GDM: Has the situation worsened with Covid?

FC: The increasing prevalence of DCA has been a constant for some time now. However, during the lockdown it accelerated dramatically in a situation aggravated by difficulties in accessing appropriate treatment. Despite the lack of epidemiological research, an increase in new cases is estimated at around 30%. The public assistance response is struggling to cope with the increased demand for treatment in an acceptable timeframe. All the more reason to increase cooperation with private sector associations.

GDM: Have the numbers only increased?

FC: No. During the pandemic period, the average age of onset of DCA also changed, dropping to 11-12 years. Furthermore, DCAs have increasingly been combined with acute non-nutritional self-injurious behaviour in adolescents such as cutting, burning, suicide attempts. A strong confusion of gender identity is also noted. Patients consider these behaviours secondary and trace them back to the communicative codes of the DCA, that is to say to the search for communication with oneself, for a passing identity in an attempt to trace these symptomatic expressions back to aspects of the internal evolutionary dialogue, even if the increasingly dissociated use of the body gives cause for concern and the recovery of the body-mind relationship becomes more complex.

Interviewed
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She is the author of several publications mainly on the topics of DCA and monosymptomatic therapeutic groups.
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