Underpinnings of the therapeutic community: individual/group dialectic, between clinical organisation and daily life

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Abstract

This contribution offers a general overview that departs, above all, from a relationship with the Mito&Realtà network, and describes the underpinning of the community architecture, highlighting the basic arrangement and internal articulations that work together to achieve the clinical, rehabilitative and social aims that form its mission. The TC is presented as a complex organism and course of treatment defined in space and time, and that develops from an initial moment of reception (trial period, assessment process and rehabilitative therapeutic contract), into individual, group interventions (assemblies, meetings, various group typologies) and interventions with families, a phase of insertion, attachment and start of detachment from the social network. Great importance is placed on daily life and the climate as background for integration and transformation, beginning with the results of the international literature and recent infant research studies on processes of affective attunement, rupture and reparation.

Keywords: therapeutic community**,** leadership, followership, tuning in, therapeutic project, case manager, *milieu*

A sound, light, mobile architecture

"In my personal view, thinking about the institution tends to take on an architectural form. Moreover, the discipline of architecture has always been on the boundary between the construction of rigid structures and plasticity, meeting the needs of the human beings who use them, ranging from the caves of primitive men (...)to the architectures of totalitarian regimes that can be recognized as unable to house living beings, to the sculpture-architectures that tend to deny the necessary institution in favour of individual instable creativity (...). Renzo Piano, with his stable and light buildings that are embedded in the social fabric, provides examples of necessary institutions: sound, light and luminous buildings (...) For example, the Beaubourg in Paris, where the structures that holds the building up are not concealed underground or covered with plaster, but overtly displayed, painted and powerful, proud of making the whole building work." Anna Ferruta, 2016)

The Therapeutic Community (TC) is a living organism, an orchestration of multiple instruments and players (workers, residents, family members, referrers, natural networks, etc.). An institution, therefore, aptly evoked by the above-cited image suggested by Anna Ferruta of a solid but light and mobile architecture.

I will attempt, in this contribution, to describe the underpinning of this architecture, highlighting its foundations and the distribution of its interior spaces, which combine to allow it to accomplish its clinical, rehabilitative and social aims. Beyond its specific objectives, it is important to categorise the various therapeutic communities (TCs) according to their diverse features. There are those for adult, adolescent and minor-age residents, psychotics, mothers and children, battered women, and so forth; typologies both long-lived as well as those that have sprung up recently across the country.

An overview, in other words, prompted by knowledge of the communities of the Mito & Realtà network that, for some years now, have been elaborating indicators that could constitute a common denominator for an Italian "community model". Despite the diversity of types of underpinnings and organisation (privately accredited or public), they do share an initial fundamental: their democratic foundation. This consists of a distinct yet conversant clinical and administrative leadership, a staff that functions as a "followership" (1) that promotes and supports its multiple activities with a group

co-responsibility oriented toward the integration (2) and maintenance of a safe and protective emotional/affective climate for residents and workers alike. (Correale 1990; Obhlozer, Perini 2001, Perini 2012; Ferruta 2012). Communities with clear *confines* but permeable and open to continuous theoretical/clinical encounter with other TCs and to integration with the local or broader regional, national and international social fabric (Barone, Bruschetta 2015).

For those seeking integration, the therapeutic community offers a course of treatment with a definite time and space in which to develop that continuing dialect between individual intimacy and private listening and group experiences that foster encounter with the other (both symbolic and real) in the multiple behaviours and projects that continuously intersect in daily life. Thus, on the one hand, it offers a "custom-fit" evolutionary project with a personalised central reference point (caregiver or psychotherapist) aimed at cohesion, strengthening of the self and acquisition of the ability for reflection. On the other, a group dimension that can increase a sense of belonging and responsibilization as the premise for a gradual receptiveness to connection with the social and family networks outside the TC. It is on this difficult co-existence and oscillation between the Self and the Other that the majority of the treatment's efficacy depends, even with inevitable upsets that range from shut-down and withdrawal to enthusiastic and often explosive immersion (Napolitani, 1987).

Residential treatment immerses us in a highly complex and multidimensional situation that requires a specific kind of organisation. Indeed, a patient in a community undergoes various "interventions" contemporaneously: psycho-pharmaceutical, individual and group therapy, psychosocial rehabilitation, family intervention, the influence of the milieu on the natural course of the disorder, contingent events, and so forth. It is therefore necessary in a TC that we speak of "therapeutic relations" rather that of the "therapeutic relationship" (Maone, 2011).
In any case, however, even for more serious patients, the quality of the interpersonal relations is revealed as the core of the practice, and favourable results stem from a wide range of settings and patient populations. Therefore, the question is to articulate these multiple settings flexibly according to the phase of the personalised and shared therapeutic course of treatment, utilising the potential of both individual and collective spaces fully.

On what does the successful development of this individual-group dialectic depend?

According to international studies (Priebe, Gruyters, 1993; McCabe, Priebe, 2004), and countless years of treatments administered and patients released, the prerequisites are the shared involvement of the patient, family, referral service and TC group in the project's construction, and the therapeutic alliance that is forged in the preliminary phase that every community that calls itself therapeutic must seek to ensure. If any of these actors either is missing, due to absence or indifference, or hinders the process for myriad obvious reasons, the task of this treatment method immediately becomes a grim drudgery that is often destined to fail. It is important to be aware of these limitations, in order to rule out idealised and unrealistic expectations that often lead to weakened caregiver motivation and patient dropouts.

1) ***Reception***

A trial period for the assessment process and rehabilitative therapeutic contract.

A stage variously known in TCs as admittance, reception, intake, and so forth, this the first group formation is intended to keep all the actors in play (Giannini, 2012). It begins with a careful multidimensional assessment that is often not performed by the referral service (overly burdened by institutional obligations), and by a period of preliminary observation. This not only in order to reformulate the diagnostic framework, through the necessary reconstruction of the patient's intergenerational history, but to construct a *filter in the form of questions* and analysis in order to *fully understand why the patient has been referred to the TC,* to then launch a conscious decision-

making process. The questions to ask could be: is the therapeutic community the right instrument at this moment for this patient? What other method could be more appropriate? In the case that it is possible to rely on a network of communities with semi-homogeneous groups or features that could be more or less compatible, how can an appropriate "match" be made between a the patient and a TC?

We believe that these types of questions, important also in public facilities, which can use a range of protection levels and rehabilitative intensity, are to be asked regardless of external pressures, obligatory interventions and financial reasons, which must undoubtedly be considered. But if these become predominant, it is obvious from the outset that they will lead to an unfavourable or partial outcome, to more frequent hospitalisations, or to self-inflicted violence or attacks on others, all of which interruptions worsen chronic problems with the consequent exponential increases in costs.

Responding to these questions, and a period of observation that varies according to the facility's availability and potential agreement among the actors concerned (in some cases even beginning with an alliance within the patient's home) leads to the therapeutic pact to which the patient subscribes at the start of treatment. This project involves the three essential levels of the person: the biological, the psychological and the environmental/social. The plan, to be checked at least bi-annually, includes therapeutic/rehabilitative and educational (for minors) activities selected in collaboration with the patient and aimed at promoting the development of his/her resources, but that also take into consideration the fragilities and dependencies (in cases of psychosis) of his/her personal existential and clinical history.

In more evolved TCs, this process is continuously monitored (with a variety of instruments) so as to assess progress or regression in various areas of the patient's mental functioning and relational networks, as well as quality of life (3) and, where possible, a follow-up at one or two years on. In place for some years now at one of our network's TCs of excellence – Gnosis – is an interesting *comprehensive assessment protocol* that covers the entire organisational architecture for monitoring progress and assessing the effectiveness of the community intervention. This involves:

- the patient (overall and cognitive functioning, personality features and level of symptoms;
- the family (burden of objective and subjective care, adaptation and flexibility in intra-familial relations);
- the caregiver (representation of the community climate, stress levels and burn-out); and,
- more in general, how the community works (physical features, institutional framework, patient and caregiver features, social climate, policies and services).

The picture that emerges, complete with statistical elaborations, (4) made available to caregivers and residents, can involve everyone in self-observation and be an asset with external institutional referents.

This routine assessment method, along with the process of accreditation, such as the "Visiting" project (Vigorelli 2012, 2015, 2016; Bruschetta, Frasca 2016), and clinical supervision, show the complexity of this treatment, and can ensure the successful maintenance of the TC's ecological progress, the prevention of chronicization and caregiver burn-out and, above all, the continuous upgrade of the treatment.

2) *Individual intervention*

Every TC offers an array of possible interventions ranging from simple listening and support sessions and personalised crisis management, to outright psychotherapy, which the resident can receive inside or outside the TC; psychotherapy directed at support and vitalisation of the Self in psychosis, and at mentalisation and containment of borderline acting-out. We will not dwell on the richness of the models used for both psychotic and borderline disorders – but would refer readers to chapters II, IV, V, VI of a book published by Mito&Realtà in 2012 (Ferruta, Correale, Biaggini, Bencivenga, Ghisotti 2012**) (5)** that addresses these individual aspects**.** Rather we would stress the importance of the case manager (supported by a micro-team) whose function is to assemble and integrate the various formal and informal aspects that residents express and project in their many in-

community experiences. In light of the developing complexity, this central figure can interface skilfully with the referral service and family to provide a dynamic and evolved representation of the patient based on gains over time, and that is partially new as compared with the initial one. Thereby facilitating detachment and a new way of reintegrating with his/her original context, especially where the resident is unable to achieve complete autonomy.

3) Group intervention

The Assembly

Since the earliest therapeutic communities in England in the 1950s, the community Assembly has been a central moment in the life of this treatment method and it recurs in all forms of community therapy. Conceived by Tom Main as a system structured around a daily routine that actively involves the residents with all the professional figures (including gardeners, administrators, accountants, etc.), and for us still valid, the community relies on the assembly as one of the fundamental ritual instruments for promoting collective responsibilisation. This through self-observation and reflection on all its internal structures and dynamics according to a "culture of inquiry".

This allows for the transmission of the community culture, relational models and practices to many generations of patients, bringing together all the therapeutic treatments and other casual, informal, formal and professional encounters. It also provides a basis for forging a common emotional bond among its members and for confronting conflicts by fostering a sense of *belonging* (6), testing the prevailing climate and confirming the values of community life (Hinshelwood, 1982; Corulli, 1997; Vigorelli, Gravina 2015).

Moreover, it is in this democratic community meeting that its *rules* are discussed, defined and recognised; rules that are fundamental to ensuring healthy co-existence and the therapeutic effect. These meetings are also a setting in which to redress the violation of those rules, express different viewpoints and test new decision-making processes according to a majority vote, under the guidance of a leadership that involves even senior residents on the basis of experience and sense of cooperation.

Finally, the Assembly is where news can be shared on the release or admittance of patients or staff changes, and participation and the general climate of the moment can be assessed.

Meetings

Every community should develop its own approach to these meetings (Ferruta, Vigorelli, 2012), but there are some constants:

- *meetings of all staff*, in which to encourage research aimed at understanding episodes and therapeutic dynamics, in order to learn from experience and facilitate a true capacity for change decision-making;
- *organisational meetings for structuring the daily routine* of the house, involving all the residents and caregivers in defined tasks;
- *subgroup micro-meetings*, in which a common thought is developed around a particular patient or situation in order to avoid phenomena of narcissistic seduction with patients and destructive competition among colleagues;
- *brief daily meetings with the therapists present*, to allow a minimum of space to think and monitor emotions in crisis situations;
- *informal spaces for communication*, spontaneous but necessarily an integral part of the group culture, as a way of cultivating an unconscious terrain of affective bonds and not of separating and denying tensions that fail to come to the surface for common reflection (e.g. eating together, having a coffee, etc.)
- *supervision/clinical conferences/support for the professional role* with experts external to the community.

Groups

In terms of the organisation of work groups in the form of continuous training, or of the group as a more specifically therapeutic instrument, the experiences of Racamier in France, the English community movement and the Austen Riggs Center of Boston, offer many useful instruments particularly focused on containing the destructiveness that often explodes internally. In Italy, Correale's suggestions on the group's positive therapeutic factors offer guidance that the majority of TCs have welcomed and incorporated.

To summarise those: first and foremost, the emphasis on *the multitude of relations* that form in a TC, and that offer each member of the group an effective experience of self-observation through the resonance of their internal content in the mind of the others, with previously unacceptable aspects of the self now potentially possible to welcome back in. Another factor is *belonging,* the *cohesion and unity of the group* that allows for the experience of the group as a single, sealed defining surface, like a skin that, once internalised, can offer a good representation of a dynamically expressed, cohesive Self. The *activation of heavily conditioning group emotions* regarding the primal mental life of the subject, which are rooted in the his/her basic emotional layout and mobilise more symbolic areas by stimulating individuation. The *integration of the Self into the community setting:* another function encouraged by the community setting concerns how to confront and handle a characteristic feature of psychosis and of the borderline function of the majority of patients affected by this type of disorder. In other words, the patient's intense and profound activity of splitting and projecting mental and emotional content onto the surrounding figures. Generally, these fragments are dispersed into the psychotic's life setting, and remain extremely scattered and blocked. We also know that it is precisely this process that accounts for chronicization. From the moment in which the patient undertakes treatment, the team of caregivers becomes the patient's mental life setting. If for no other reason than that the patient's entire life takes place within the facility, the TC becomes a container in which those fragments can be brought closer together. They will go on to be deposited on the caregivers, the facility as a whole, the rules and the other patients; and if we pay close attention, we can at any moment discover on which caregiver the patient is activating some aspect of his fragmented mental life. The professional group thus has the possibility, through team meetings, to remobilise the parts of the patient that have split off and re-examine them creatively. Each fragment can be enriched by its passage into the mind of another, and through the encounter of various points of view. The team will find itself working *with* and *for* the patient to arrange and integrate those fragmented bits of experience that is normally a task performed by a functioning Self (Bruschetta, Bivone, Barone, 2011).
Finally, the group as a laboratory for experiencing *connections with the external social networks of the group/community*, which increases its ability to be receptive to contacts and exchanges with the fabric of relations – family, friends, workplace and institutional – offered by society. "Social networks, like all natural systems, are not static and crystallised, but traversed, indeed made up of, psychological/group dynamics that continually modify the identity of problems and the quality of bonds. The rich and fertile nature of a network stems from the interchangeability of problems and the insatiability of bonds (…). Networks are built of weak, strong and intermediate links (these latter have an explicit therapeutic function)" (Bruschetta, Bivone, Barone, 2011).
In particular, attention to the societal and workplace inclusion of residents is one of the fulcrums on which all TCs actively collaborate with referral services, families, user and family associations, foundations and companies, and come up with creatively courageous, but realistic, solutions. A good example is the recent experience of a social farm (in Sicily) managed mainly by users and member of a network that is creating innovative and integrated work prospects in Italy (7).

We find a complete descriptive and technical mapping of the various group activities that could be extended in part across the network of communities in the article, "*I gruppi in comunità terapeutica*" by Corulli and Olivero published in 2011 in the magazine *Terapia di Comunità* (8), that covers: groups on co-habitation, reception, cognitive rehabilitation, crises and

psychopharmacology; small therapeutic groups, expressive groups, seniors groups, groups on relaxation and non-verbal techniques, sports groups, weekend groups, job insertion groups, self-help groups, and so forth.
Particular attention goes to the settings of these groups, their aims and the referrers who involve the residents as much as possible in organisational management. Even group psychotherapy for patients with personality disorders are given meaningful space, beginning with the Bateman and Fonagy model, which is effective for developing mentalisation ability and emotion regulation, and in which group psychotherapy offers an efficacious context in which to focus on one's own mental state and that of the others. It stimulates highly complex emotional interactions that can be channelled in such a way that every patient explores his/her subjective understanding of the motives of the others and, at the same time, reflects on his/her own (Bateman, Fonagy, p. 157).

4) ***Family interventions***

The traditional Italian family's current state of crisis and evolution, with rearranged families, single parent nuclei and the migration phenomenon that leads to uprooted families, is leaving increasing numbers of community residents without stable or reliable family reference points. These phenomena make it difficult to develop post-community plans, and suggest insertion into the local network nearest to the TC both from the employment standpoint as well as living arrangements.

On the other hand, when these bonds are still active, it often happens that the community treatment period offers the family a good opportunity to finally understand the origins and substance of their member's disorder, and to learn new ways of interacting and new behaviours. For some it could even shine light on their own personal history, i.e. couple-relations and transgenerational trauma that afflict the majority of the families of residents. By working with them as co-actors in the therapeutic project, the TC can gain valuable tools for reconstructing the resident's family saga, and identify potential. The important thing is that the TC be willing to accept that the family is not an obstacle but a resource with which to work, in order to encourage encounter and re-interpret the dynamics in the hopes of transformation.

By now all TCs cultivate this attitude in various ways, through multi-family groups or periodic encounters with the parents, which facilitate constructive collaboration and, where possible, help in the creation of family associations linked with the host communities by making accommodation or work resources available and welcoming new families through a form of self-help (see the "Gnosis" or "Sabrata" TCs).

One best practice worthy of note is the systematic work with family members carried out by the TC "Passaggi", which has developed a winning methodology that, over the years, has fostered positive outcomes and a very low percentage of dropouts in the first six months. The course of treatment is as follows:

- **A psychiatric examination and a family meeting** both conducted by the Healthcare Director and the head of the assessment phase, during which the applicant can visit the community and express his/her opinion on its adequacy to meet this/her needs. The older residents, selected by the other residents during the weekly assembly introduce the organisation and explain the daily routine of the community to both applicant and family members.
- **Home meetings** (at least two) by the caregiver of reference at the habitual residence of the applicant, the frequency of which is correlated both with the possibility of creating a bridge-relationship (a prerequisite for a good therapeutic alliance), and that serves to address the anxiety associated with separation from the family setting, and with waiting times owing to the actual availability of a place in the community. In these meetings, the caregiver enters into contact with the real life context of the patient, the social reality in which very often many symptoms are explained. The caregiver further explores the family dynamic in its natural setting

and all this information goes into forming an acquaintance with the patient that is essential to offering the best possible access to the community.

- After the initial getting-to-know-you phase, a personalised rehabilitation programme is designed that includes the family members and/or other significant persons' roles; monthly home return visits; a programme of eventual visits by spouses, companions or other significant figures; **Meetings with family members** that, in accordance with needs, can begin even before the future resident's entry into the community. The meetings are conducted by a psychotherapist with community experience and group analysis training. The case manager joins the therapist in the meetings with the aim of encouraging expression of the daily routine of the patient and as a link between him/her and the family. Initial meetings include the presence of both parents or, if these are separated, separate meetings. Siblings and other significant persons are usually called upon to participate in order to have as overall a vision as possible in this exploratory phase. If the applicant has no family, other figures are identified: administrators, friends, social workers, etc. Family meetings are generally held on a monthly basis, but can be held every 15 days in some cases.

Multi-family groups: This method, born of the multi-family psychoanalysis of Badaracco, encourages the construction of a new scenario, within which various nuclear families, including the patients, are given the opportunity to compare their experiences and work on them in front of a large group and with its help: "*on the articulation between one family and another, foregrounding the wealth of similarities, differences and contradictions, so as to generate new individual and family organisations at the same time*" (Badaracco 2000). The multi-family group can involve, upon agreement with the caregiver and patient, even relatives and volunteers as instances of socialisation. The multi-family group is conducted by a TC Director with group analysis training and a mini-team composed of the community coordinator, the head of family meetings, 4-5 caregivers, interns and observers as recorders. The multi-family group meetings are on a monthly basis and last for two hours, with half-hour meetings before and afterward for the Director and mini-team.

Daily routine and climate as working background for integration and transformation

Cited in many international publications as a feature specific to communities, the "therapeutic climate" has been considered an accessible and mediating factor in the community therapeutic process since the research begun in the 1970s by Rudolph Moos and his American group, which have built a conceptual model and a specific instrument for its exploration and evaluation. The climate (9) is described at various levels, assessing all the factors that contribute to creating the community's environment and that interact as a result of a particular climate or atmosphere that, in turn, influences the residents' continuity in the therapeutic programme and its outcome, especially in view of their more functional return and adaptation to external society.

The factors, according to this model, that determine the treatment climate are:

1) the *TC's physical and architectural features*, such as the comfort and sensory features of the spaces made available to residents and caregivers;

2) the *institutional context,* policies and organisational aspects regarding services provided;

3) the *human factor*, features of caregivers, patients/residents (demographic data, health conditions, resources, etc.), as well as the quality of their relationships.

These concepts have been absorbed with enthusiasm and conviction by Italian TCs as a subject of study (creation of a recently approved evaluation instrument (10) but even more so as a clinical practice.

Starting with these factors, how can the daily routine act as a powerful trigger for change?

We find this question's answer in recent infant research (11) studies regarding the shared implicit relationship as the continuing interactive negotiation process that characterises the relationship between the child and its nurturing environment from its first months of life, and concerns the awareness of "being with someone" (Stern, 1985,1995). These procedural forms of knowledge

defined as "implicit relational knowing" are, in both affective and cognitive terms, located outside awareness (before the appearance of language) and the dynamic unconscious; they develop parallel to an organising function and are present in the pre-symbolic infant, but continue to operate for the rest of the person's life.
The transformation of the relational system manifests itself therefore through micro-processes, intimate interactions, "small mutually constructed 'collaborative dialogues', largely out of awareness, over an extended period of time" (Lyons-Ruth, 1999, p. 579). The concept of implicit emotional processing refers to memories or perceptions that involve the amygdala and the limbic system. An example of this implicit emotional knowledge is given by the fact that it has been proven that adults process facial expressions and involuntarily coordinate with them in the space of 30 milliseconds. This shows that it is possible to inadvertently evoke positive and negative emotions alike since important aspects of face-to-face communication take place on an implicit level (Dimberg, Thunberg, Elmehed, 2000).
If we think of the community's daily routine as filled with contacts and avoidance, expressive facial movements, rhythms and intonations of voice and gestures that are generally implicit, micro-moments mainly occurring in informal spaces in which residents and caregivers engage in spontaneous and unplanned exchanges, transactions with emotional and gradated sensory climates, we become aware of the vast wealth of transformational possibilities that await care workers trained to observe and assess these relational modes (D'Elia, 2000).
Also interesting to apply to the context or the daily community routine are another two indications that stem from precocious interactions: the reciprocal interactive regulation in face-to-face moments marked contrapuntally by ruptures and reparations and the *process of tuning in*. Tronick maintains that interactions have a positive outcome when self-regulation and interactive regulation are in equilibrium, just as the experience of repairing non-coordinated states (much more frequent) contributes to increasing relational skills. The fact that reparation is predictive of a positive outcome in development, and that what prevails in pathological states is self-regulation, suggests that caregivers need to be prepared to respect the patient's self-regulation phases and be empathically accommodating when it is time to enter into a relationship. And in the face of episodes of rupture, to work patiently to repair them, thereby contributing to growth of the sense of self and to tolerance and the non-catastrophic experiencing of eventual future relational ruptures.
As for tuning in, which is essential to recuperating aspects of primitive insufficiencies of the Self, researchers remind us that flexibility and medium intensity coordination underpins safe attachment, while an excess of coordination is a harbinger of insecure attachments, with the attending vigilance, control and sense of alarm. Just as too low a level introduces a strong need for self-regulation that leads to elusive attachments and withdrawal. This is a signal to modulate both lack of stimulation as well as hyper-involvement with residents, approaches that perpetuate the pathological interactions experienced in pathogenic family and social relations.
This rhythmic and regulated, but also informal and undifferentiated daily routine represents the humus, the fertile terrain for gradual, silent integrative processes, scattered and fragmented somatosensorial elements of the group field and the internalisation of new and meaningful relational patters. The container of all this is that "sound, light and mobile" architecture that, in various moments of self-observation, averts the "chaotic dispersion of meaning" fed by the pathological need to "hold" together the broken elements of the psychic and relational field, and restore to the patient a wise and agreeable representation of his condition and its possible evolution (Biaggini, 2016).

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Notes

(1) The followership consists of "precepts of training, responsibility and authority that allow workers to function as a system in support of leadership "(Obholzer, Perini, 2001).

(2) "Leadership's essential function lies in its ability to generate dialogue at both organisational and group level, with a view to the fair distribution and enhancement of members' diversity" (Correale2006).

(3) (CT Il Porto, CT Passaggi, CT le Vele, CTA Sant'Antonio, CT La rosa dei Venti, CT Piccola Stella, CT Eimì ecc.).

(4) The design of the assessment and data analysis protocol is coordinated by Grazia Serantoni of the "La Sapienza" University of Rome and is a *best practice* born of the "Visiting" experience.

(5) See: Una cura comunitaria per quali psicopatologie? *Anna Ferruta*; Psicosi e lavoro terapeutico in comunità, *Antonello Correale;* Il borderline e le regole istituzionali comunitarie, *Antonello Correale;* La Comunità Terapeutica e il paziente Borderline e Antisociale: l'esperienza della Comunità Il Porto, *Matteo Biaggini, Metello Corulli*; Comunità terapeutiche per adolescenti e fattori di criticità, *Claudio Bencivenga* ; Le comunità residenziali per minori come strumento di tutela e di cura nella rete dei servizi territoriali, *Norma Ghisotti.*

(6) In the important article, "How therapeutic communities work: Specific factors related to positive outcome" published in the on-line magazine, "*International Journal of Social Psychiatry* del 20 July 2012, Steve Pearce and Hanna Pickard (Oxford UK) report on the data of recent international research, summarising the fundamental therapeutic factors of TCs as belongingess and responsibility, stating that: "Belongingness constitutes a fundamental human motivation. The belongingness hypothesis claims that: *human beings have a pervasive drive to form and maintain at least a minimum quantity of lasting, positive, and significant interpersonal relationships. Satisfying this drive involves two criteria: First, there is a need for frequent, affectively pleasant interactions with a few other people, and, second, these interactions must take place in the context of a temporally stable and enduring framework of affective concern for each other's welfare*." (Baumeister & Leary, 1995, p. 497).

(7)www.fattoriesociali.it;www.liberamentefano.com;www.fattoriesocialisicilia.com;www.agricolturasociale.it

(8) Barone and Bruschetta, in an interesting article entitled "La comunità terapeutica nella comunità locale per la cura della grave patologia mentale" (2015), offer a map of the groups based on their group analysis expertise and the experience of the DTC in Sicily:1) GROUP THERAPY TREATMENTS: - activity groups – organisational and management groups – expressive/relational group laboratories. 2) SMALL PSYCHOTHERAPY GROUPS: - small psycho-dynamic groups – with expressive aims – with analytic aims 3) LARGE PSYCHODYNAMIC GROUPS: – with intracommunity aims – with community aims of multi-family psychoanalysis. 3) VITAL AND OPERATIONAL GROUPS – operational groups – aimed at personalised therapeutic planning – aimed at specific services - vital family therapy groups - small family therapy groups – society-workplace inclusion groups. 4) SUPERVISION/CO-VISION GROUPS: - clinical supervision/co-vision groups- group superivsion and institutional analysis groups – co-vision groups focused on vital groups.

(9) "The most important factor in efficacious psychiatric hospital treatment seems to be an intangible element that can be described at its atmosphere and, in an attempt to describe some of the influences that contribute to the creation of this atmosphere, it must be said that the more psychiatric hospitals imitate regular hospitals, the less successful creation of the necessary atmosphere will be. Too many psychiatric hospitals give the impression of being midway between a hospital and a prison. Its role should be another one: that of community therapy" *(Third Report by the WHO Expert Committee on Mental Health, 1953)*

(10) The Community Functioning Questionnaire (CFQ-i 28) assesses a group's working capacity, its leadership and process of responsibilisation and the image of a "the therapeutic climate that emerges in group meetings" and the other on "organisational climate" (Chapter XIII. Stirone, Peri, Vigorelli in Ferruta Foresti Vigorelli (2012*) (*edited by*) Le comunità terapeutiche. Psicotici, borderline, adolescenti e minori,* Cortina, Milan.

(11) These authors' method of observing the mothers-child pair permits the measurement of micro-analytic interactive, face-to-face, exchanges using two visible and synchronised cameras that film the pair in a 4-5 minute close-up at 24 frames per second. The film-frames are codified according to pre-established criteria and record data not observable without instrumentation.

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