PSYCHIATRIC ADDICTION-THERAPY:
TOWARDS A DIPENDENCE PSYCHOPATOLOGY
GROUP FOR PSYCHOLOGICAL FUNCTIONING RESTORING (GRF-p).

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INTRODUCTION

In several nowadays clinical manifestations we can see a common feature: the weakness of the narcissistic personality structure.
We have a continuous increasing range of patients who can be difficultly assessed by the classic descriptive psychiatric nosography and who lets us think about the existence of an underlying narcissistic structure that is more correctly defined as Self-weakness.
These subjects are more or less exactly defined as "new patients", because they apply to our structure with a transnosographical and diversified symptomatology that is hard to settle within a defined sphere. This problem is generally solved by using more or less right diagnosis with the various axes of DSM IV-TR.
Many psychopathological manifestations, now described in a transcategorial way, reveal, if considered with a stronger attention on the dimensional approach or in the continuum, to have a common matrix: addiction and consequently Self-weakness.
We concern, in this article, the so-said addiction patients: those patients who hide behind symptomatologic expressions that don't immediately recall the addiction area.
We began to pay attention to the common features that concern our patients. This allows to get the substance of the problem, leaving aside the problem of the substance. We underline where the fragile subject looks at: outside, looking for real substances; but also if he shows a different kind of addiction (relational, behavioural, objectual).
The pathologies, that we here concern, are not only those ones where the addiction aim is recognizable as substance, but also those ones where a behaviour (pathological gambling, compulsive shopping, technological addiction, working addiction, etc) or another kind of psychic addiction provides excitement (the so-said psychic substances).
Object substitution, hunger of the object (Kestemberg), excitement that the object provides are the main concepts that influence this approach. Beside this also the correct distance from the object, that we translate with the correct distance from the patient who gives to the relationship with the therapist an objectual meaning.
By following the red-line that is leading our thoughts, I'm clarifying my approach by using some summarizing panels, by illustrating an exemplary case and by suggesting some other examples.

ANTONIO: THE WAY HE LOOKS

Antonio is thirty-eight and he comes to the CPS for a first examination.
In the two last weeks he is afraid about the fact that "Human mind is able to do anything" and this thought causes him a great distress.
The stress-events are a colleague's suicide, an aunt's disease (Alzheimer) and another missed suicide of a neighbours' son. Furthermore he says that "If people listen to news, they should be worried by what they say".
Painful moments break him through, he's afraid about the possible consequences: so he comes to the department.

SQUARE 1: THE SELF AND THE NARCISSISTIC STRUCTURE.
By the developmental point of view, Self is generated inside the relationship "Mother-ambience-child" (Winnicott) and "it's a self-erotic organization that contains the object even if the object is not yet represented or imagined as something differentiate from the Self"(Kestember). Before getting the capability of object-representation, child is able to have "a primary identification" with his mother-ambience.

The introjection of the reverie (mother's mediation function with the outside) goes together, in the first child's experience, with the pleasure of the result. If this happens, we see the birth of a basic narcissistic structure that will be able to feed the vital attitude, a positive way of facing life that last all life long: this is what we call basic confidence.
In this sense, Self and narcissistic concepts have a common ground (without any connection to the classic and complex concept of primary narcissism).
"We don't notice the sufficiently good-autoerotism if it works" (Zucca Alessandrelli, 2001): it's the condition of the child who, beyond the experience of a pleasant functioning, introjects foundations to differentiate Self from the non-Self, the inside from the outside. As Winnicott said "In order to build the object, we need it to be already present": the quality of the pleasure that child feels in the relationship with the mother and that at the beginning he ascribes to himself, is the basic condition for the birth of a healthy capability of thinking and of building the self-consciousness. This birth (as Zucca Alessandrelli says) goes together with the "bent towards", with that senseless and enough megalomania confidence, that reality is there, waiting, and that all needs will find their satisfaction and pleasure (ibidem)".
The capability to stand the waiting, in the first experiences of distance from the object, builds a screen shield, a primitive form of independence from the object, the affective ground of its representation. This screen or protective system continues developing gradually through child's growth, together with his mother (who is a function, a holder and a process) who takes care of this growth.
In the first life period the function of the screen is to shelter from the too strong stimuli, for example allowing the baby to fall asleep.
Afterwards the child will be able to face the situations that growth bring with, without turning to violent or aggressive defences; with other words maintaining that confident attitude that he learned to have towards himself and reality.

Afterwards he describes a problem that he defines as a secondary problem: since two or three years his partner and he go to the gambling house and loose a large amount of money. They have been playing for a long time, but recently gambling is more and more assiduous.
Many years ago Antonio gamed on the Stock Exchange and he lost all the money he had gained by selling a small inherited flat; as he lost everything he had, his partner and he go and live with his parents.
Antonio is very nervous, he has many facial tics but he describes himself as a sweet-tempered optimist person.
Now he lives with his father who enjoys good health and whom he describes as a fussy father who is always right, "troublesome, but much healthy".
His mother died in 2000 and she was "a wall-flower, lived for my father and for me, she had no demands and she never asked anything for herself". Antonio is only child.
He asks for help, without exactly knowing the matter of this request. The main problem we notice is the great fear of loosing control and the fear for damaging himself or someone else (Antonio doesn't say this clearly, but we can sum it by his speech).
In the last two weeks he lost weight and he began being sleepless and anxious.

SQUARE 2: THE FRAGILE SELF
If a person begins soon in his life to know failure in experiencing his capability to react to relational stimuli, he won't develop a sufficient basic confidence. The memory of those first failures will come out in the adult period under the form of hypersensitivity, touchiness, vulnerability, disesteem all characteristics that reveal the incapability of the person to mediate between inside and outside: the fragile Self.
Self weakness brings people to desire, at a deep level, to be accepted in a total and unconditional way; the relationships that a person with this structure looks for are filled with symbiotic needs and with expectations full of idealization. In this way weak Self works as a motivation to increase addiction. The relationship with others is only to all appearance turned to the outside; what the person with a weak self is strongly and really looking for, is to try to fill with the object the deep emptiness that pervades him; he won't really

never be able to fill this emptiness, because the unconscious cannot be satisfied.
Otherwise, the more the other is important, the more he is felt and used as a prothesis of the missing elements of the self. The external object is not separate and differentiate, but he is dressed with primary functions like mirroring, protection and acknowledgment. When the object is not available, the person with a weak Self lives an experience of deep grief.

THE ADDICTION PATIENTS: FOR A PSYCHOPATHOLOGY OF ADDICTION

The patients with more or less deep failure in the Self structure are often assessed, even if with uncertainty, in the area of neurotic disease or as a borderline. These patients use defences mechanisms that suggest a diagnosis on axis I or that bring us to think about the manifestation that underlines a difficulty with the control of the impulses.

We could, as Jeammet says, talk about a real addiction psychopathology: " … I don't mean that addiction itself can explain the birth of these eating disorders, neither that we see no other conflictual dynamics; but conflicts are not enough to explain certain common characteristics that can be better understood and faced if we consider addiction that can help to clear, comprehend and lead our therapeutical attitude. The recognition of behaviours that allows us to think to addiction, can help to understand how to assist these always more numerous patients. They mainly show "actin-out, where the behavioural dimension takes the power upon mental, symbolizing and intrapsychic dimension (Jeammet)".

This kind of eager object relation, to which the addicted too strongly clings, has the effect to produce therapeutical relationships at all appearance opposed: sudden breaking-off by one side and endless therapy on the other side.

SQUARE 3. THE ADDICTION

The term derives from the Latin word "addictus", that in roman civilization was the insolvent debtor condemned in slavery and bound all life long to his creditor.
We can use this term to indicate the condition in which we always have to add something to a self-consciousness.
We can mean addiction as the necessity to add something because we need this in order to have the possibility to live: this is the condition that mainly marks narcissistic suffering. The retirement upon the substance-object ("the hunger for the object" according to Eveline Kestemberg) that brings the subject to look for the physical substitute of the emotions that he cannot experience, shows the ill side of what we call addiction. Addiction is the attempt to give a support to the Self by a physical satisfaction that is possible only with the presence of a substitutive object always at all appearance available: the only identity element is the sensory one as a substitute of affects and emotions. This surely happens in the addiction for substances, but a kind of sensorial satisfaction is also present in eating disorders. In this morbid condition we can see that body is not only the place for sensoriality, but also for identity (The value of Self through the weight in anorexia, for example).
Other forms of expression of addiction are those behaviours through which the subject restores a primitive sense of the Self through a psychical excitement.

According to these observations, we have to think about a treatment that helps to restore psychological functioning. A treatment that supports, precedes and succeeds other cures that severity of the disease asks: here we introduce the "GRF **"**(Zucca Alessandrelli). The addicted patient has many difficulties in the description of his disease: he has a low capability of psychologizing it, of mentalizing it. He asks more for things than for treatment: he looks for immediate magic solutions (that he already tried to find autonomously).He often moves a sense of helplessness in the clinician, who cannot keep the right distance and to build a therapeutical project that is adequate to the patients. The clinician is moved to act and often suggests a too demanding treatment that doesn't consider the low critical and auto reflective capability of the patient.

This reduction comes from the fickle consciousness of the patient about being and being worth that lets these subjects sometimes appear naives because of their tendency in undervaluing the consequences of their

behaviours.
In the most severe cases superficiality can bring to acts and not self- or hetero- preservative behaviours.
In addiction psychopathology we see more or less relevant modifications of the subjective habits, but we can also see a change in the individual pathologic way of expression.
Actually scientific community is almost unanimous in considering addiction as a psychological problem, a condition caused by persistent changes in structures and in mental functions (Pani, Biolcati).
From this point of view it's clear how narcissistic and addiction problems, strictly related, are basic elements in the system of essential psychic functions.
Our chance to influence with pharmacotherapy doesn't give satisfying results; cognitive therapy seems to give temporary results, above all if the patient's structure is weak. They give not lasting results because they cannot help the patient to become more confident with his Self. The capability of acknowledging his own Self and of taking care of it is not trained.

SQUARE 4. HEALTHY DEPENDENCE AND MORBID DEPENDENCE
We can underline two different kind of accepted dependence, with diametrically opposite consequences. The first is one-way: the direction is from the subject to the object, with a parasitary characterization (lack of object-interiorization, and a real and eager need for the object). This relationship needs to last non-conflictual and idealized, in a basic narcissistic way.
The other kind of relationship "is characterized by the support of external objects, in order to allow the Ego to carry on its elaboration and interiorization process: this direction is not one-way, and this is what we call healthy dependence.

We can meet some difficulties in recognizing addiction in subjects who lead a common life, subjects who show no addiction behaviours: an addiction without drugs (See c).
We can at least differentiate four kind of addiction expression:

a) Addiction to substances: like all drugs or food cause physical sensations through which the subject perceives himself and feels he is alive.
b) Addiction to excitement produced by peculiar behaviours: gambling, kleptomaniac, compulsive shopping, videoaddiction, transgressive and dangerous sexual behaviour.
c) Addiction to common behaviours of "normal" life: like job, success and power, being perfect mothers or blameless housewives, altruistic father of a family, but frustrated in affects and sexuality. In this group discrimination between normality and pathology is hard to do: we can see that behind some moralistic and often ego-syntonic attitudes the subject uses to adhere in an excessive way to assented social models; models that work as a defence against depressive feelings, of interior emptiness (Giannelli). We talk about hyperadapted patients who built their life safe from any emotional danger and who have a fluid Self (according to Bauman). A Self that, like liquids, adapts itself to the shape of the container, because they don't have on his own. They don't recognize their addiction problem, they don't feel conflicts because they live their addiction as egosyntonic. This brings their lives to dead-end track: boredom, few emotions, faded affects, loss of the capability in planning let these subjects become chronic depressed people, difficultly bearable to relatives. Often, with a more accurate anamnesis, these subjects will disclose us, inside a relationship based on trust, where they go to "catch the fuel" (as a patient told me, speaking about his irremissible habit to go to prostitues on Saturdays afternoon) in order to keep far the depressive and painful backgrounds and in order to bring on their scripts.
d) A fourth group is composed by those subjects, mainly adolescents, who suffer from depressive apathy. A kind of depression that basically shows a precautionary and filled with anger retirement from a too much exciting reality, too much dangerous for the own psychic entireness. We can see these aspects also in those patient who can get to a self- or hetero- addressed violence as a cathartic and liberating moment from an intolerable anger in front of their incapability of being independent, of being people able to recognize their own needs and consequently to provide to themselves. This anger is acted against their own weakness. We are talking about those patients who are included in the category that I sometimes defined as "without psyche" With this term I concern a concept of no representational mind. The disease can be shown through a kind of claimfull anger that often brings to ask for objects, to apply to the external object or to forgo in order to estrange oneself from reality. Following a continuum of severity, we can get to extreme cases: I mean those youths

who commit sensational and irresponsible acts, that after they strongly deny and that bring them to courtrooms: "He was a quiet and good boy, and look what he's been able to do…" so he was described by neighbours. These examples represent an excess of the narcissistic continuum, but it can give a hand to look at the problem from a different point of view.

Addiction patients call our attention, in one way or in another. Well, do we know the right key to press or the right distance to keep in the relationship with these patients? This contribution is trying to ask these questions and takes suggestion from the application of new treatment methods (see next paragraph).
Even if these new patients' generations don't grow in violence, abuse, non-affective and abandonic families, they are however sons of these ages. Ages when, in a short time (as Zucca Alessandrelli writes on "Argonauti"), we have been attending the loss of the "father of a family".
Between eighties and nineties we have been witnesses of the "fall of Gods", where also the fall of Berlin wall opened new possibilities, not only social and economic, but also psychic.
Family structures and social rules and perhaps inside our psychotherapy studies " The Oedipus telling left space to related iconography".

DEALING WITH ADDICTION PATIENTS IN A PSYCHIATRIC SERVICE.
In the analysis of the demand of addicted patients we have to remember that the Self weakness theme is not always clear and has no evident addiction symptoms.
The territorial competence is extremely heterogeneous (Clinical cases, square 5). Besides, patients with a mono-addiction have other places where to address: the patient who comes to territorial psychiatry is much more complex and the way he shows his distress is much varied.
The problem about how to treat these cases is surely actual: often pharmacological therapy is not sufficient or, however, a psychotherapeutic or sociopsychoeducational support is necessary.
In the territorial mental health service of the UOP Policlinico Foundation we experienced for some years (2005-2008) a psychotherapy model of slow-open group (GRF-p), borrowed by The GRF(Zucca Alessandrelli).
The vague request for treatment of this apparently heterogeneous target has moved in our research group many considerations that leaded to the preparation of this therapy in a slow-open group.
The guideline is psychodinamic psychology, because the method makes a use of psychoanalytical knowledge that concerns the psychic development of the person. In spite of this, it's far from the interpretative way of conducting psychotherapies, from the classic way of application of the psychoanalitical concepts and from the classic style of conduction. We should define it as a Self-restoring treatment, that can be supported by other kind of treatment.
This kind of group is an answer to all we said about the extreme narcissistic weakness (Square 1 and 2) of these patients: everyone of them is hypersensitive, vulnerable, and afraid of the affective world that they try to escape from through the substitutive object and through disposable relationships. The only possible experience is the present "*Life is now"* and it's not possible to experience the affective warm given by the bond between past and present and by the simultaneously tension towards a future coloured with confidence and hope (and not with megalomanic omnipotence).
The addiction patients seldom ask for psychotherapy, even less a psychodynamic therapy. They often hope in an ambivalent pharmacological magic solution, in order to get out of almighty point of view with a solution that allows them not to be an active part of the process, but through a fast and checkable resolution of their distress.

SQUARE 5. EXAMPLES OF CLINICAL CASES: THE WAY THEY LOOK
- A.R, woman, 32 years old, manifest obese. She comes to the service with a series of symptoms like lump in one's throat, anxiety, effort in controlling bulimic impetus (she doesn't expel food). In the past, and sometimes nowadays, she suffered from pain attacks. Her childhood is characterized by a violent relationship with her father , who beats her till she's 24 and by an underrating mother (she tells her A.R. she's fat, she leaves A.R. alone during the week-end). She witnesses many quarrels between their parents. Nowadays symptoms begin after father-in-law's death (seen as a good-father) and after the consequent presence of the mother-in law in A.R.'s family. The mother-in-law is underrating and intrusive like her mother (especially with interference in the twin sisters'education). Anti-depressant pharmacotherapy causes her gastro-intestinal side effects. She tells she lost her point of reference (her father-in-law, with the consequence that her husband becomes entirely dominated by his mother) and that she addresses to food with eagerness.
- M.P., man, 38 years-old, married with children. He describes himself as an exemplary husband who gives the family everything it needs, excessively involved in producing income through his nonstop job (he is an agent). He allows

himself some extra-conjugal flirtations (also mercenary). As his wife discovers for the second time these extra-conjugal flirtations, he begins to feel depressed and he feels humiliation, shame and disesteem. He begins thinking about suicide, he reminds about a period of his life when he drank too much alcohol, in a pathological way: he could take a distance from this life through the new "rule" of father of a family. He is afraid to fall again in the alcohol addiction and of the possibility of a suicide. He thinks that if he forwent alcohol, in the same way he can give up the excitationof the extra-conjugal flirtations without loosing self-esteem so strongly correlate to the both sides of the coin (the good father of a family and the needy boy for strong emotions in order to feel alive)?

- M.B., boy, 20 years-old. One Emergency unit admission because of an acute and transient psychotic reactive episode with persecutory ideas (he says he is followed by psychologists controlled by his mother). His mother is anxious, intrusive, and underrating; his father is marginal, weak and hardly idealizable. As we know he is not a good student and he goes round with "disco" friends. The psychotic episode follows the consumption of ecstasy. The persecutory ideation gives up in few days with the dispensing of Aripiprazolo. He spends his time at home, without doing nothing, watching TV or playing with PC. Sometimes he is reactive with his parents, but he has never beaten them. He describes himself as a shy person, he refers problem in the relationships with girls,he tells that the evening-spinel allows him to sleep quietly and to spend times (the only ones, he says) that make him feel alive or that make him feel sensations that fill a deep feeling of interior emptiness.

- C.B., girl, 25 years-old. Her father left the family when she was thirteen; it seems he raped her. She lived with her mother who has a rigid, emotionally cool and who preferred his brother to her. The patient develops food-related symptoms (of a restrictive kind, alternated with bulimic episodes). The disorder is not so severe to compromise her weight, even if she often weighs herself and refers to feel a worthy person only if she gets in a definite range of weight. The periods of food-related problems takes turns with the use of alcohol. Whenever she gets a "strong activity" (courses, exams or jobs) she is able to feel better (she says she feels less sufferings), and she seems that emptiness is less strong. She has no self-esteem, she is touchy, she stands the relationship with the health operators only if she thinks that they are taking care of her body; when emotions and affects get inside the relationship, she disappears for long time: during this time she turns to object- substitutes, and she begins looking for a presentable self-image (the self- value through the weight) that she is going to present the next time she goes to the health operators. In these times she also adopts non-conservative behaviours ("this allows me to ask without speaking, for I mean nothing to none)

Otherwise they ask the psychologist practical suggestions that wipe out any symptom, that they live in an egodystonic, threatening and meaningless way. Even when they come to our attention, they only seem to recognize their disease in a superficial way: they don't ask for treatment , they simply ask for material things; they don't give voice to their need, but to their needyness.

They show a basic organicistic thought (Giannelli). They upset psychiatric service , because they move dysfunctional (nursing or expulsive) countertransference. They mainly lead health workers to distress and impasse, and it becomes difficult to give a right placing at a diagnostic (both categorial and psychodinamic) level.

How can we encourage the change, without strengthening a generational transference, too much exciting for their weak psychic system?

We'd like to drive health workers to think about new devices (setting, techniques and management style), starting from the concept of "right distance" from a too much exciting object-cure in order to avoid the numerous cases of drop-out: if the reason for these drop-out is not clear, we run the risk to discredit psychodynamic psychotherapies. The failure of some psychotherapy is caused by the difficulty in recognizing the function arrest, because of objectual obstacle.

Modern psychodynamic theories show the importance not to drop the investment upon the subject, upon his development and upon his awareness: only a fitter subject (under a psychic point of view) is able to make us not only of introspective helps, but also of pharmacological treatments: medicine and doctor are seen in a less invading way and can be accepted by the patient. Racamier wrote much about this aspect.

These assumptions increase the value of group-psychotherapy, that is the best expression of the concept of the "right distance" and of the construction of a thought-shareable and not almighty area. Group-psychotherapy is suitable for addiction patients, but we have to introduce some characteristic precaution: a pre-determined end, the active conduction, the use of the focusing and the easing of cohesion processes, the development of the peer-group, leaving interpretative work on the background.

SQUARE 6. THE "BORDERLINE" PATIENT AND ADDICTION.

It often happens in the clinical practice to put the diagnosis of borderline personality disorder to patients who seem changeable, vulnerable, superficially tied to substitutive objects, touchy, changeable in their relationships and in their sense of identity. This lacking sense of identity is sometimes caused by primitive defence mechanisms that place these patients in the area between psychosis and neurosis: the classic nosography identifies in the "borderline" a pre-psychotic subject. If we use DSM, the multiaxial and categorial system, we risk to overvalue this diagnosis, because the phenomenological description of this personality is too much wide. But this diagnosis can contain not only those severe Ego defence mechanisms that Kernberg identifies as tipically borderline, but moreover a series of objectual supports.These latter patients, if properly understood in the pathogenic age, can be treated with a proper intervention. If it's true that the Borderline patient can be a habitual drug user to stand his psychic suffering, it's also true that many addicted patients seem clearly borderline because of their variability caused by the presence/absence of the substitutive object or because of the easiness through which they go from an object to the other in order to fill their weak self.

THE DEVICE OF THE GRF-p FOR THE PSYCHIATRIC SERVICES.

The GRF-p is the adjustment, in the psychiatric field, of the model studied and applied in the drug addiction sphere in some Sert (service for drug addiction) and in Cart (a psychotherapeutic centre for addiction) in the so called *Contraddiction* project. With adjustment we mean some slight methodological changes, that don't affect the efficacy of the device.

It consists in the introduction of heterogeneity of the patients in a territorial psychiatric service that suggests us a more complex thinking about the selection processes and group cohesion.

SQUARE 7. WHAT IS THE GRF-p

What it is*: predetermined duration group treatment for patients who come to the Psychiatric Service.*

Prescription*: symptoms and behaviours ascribable to peculiar addiction characteristics. Apparent heterogeneity of the patients, basic homogeneity in self weakness.*

Setting*: 35 weekly sessions.*

Number of admitted patients*: from five to ten.*

Conduction characteristic*: focal with a very low interpretative rate; creation of a pre-objectual ambience oriented (Kumin) to restore the conditions for the Self restarting; massive use of the peer-group work; continuous reference to the focus and to the themes connected.*

Where*: in the territory of residence or anyway in a middle locus.*

Aims*: allow to the patient to understand the current reasons of their addiction needs that are sometimes manifest and some others ill-concealed behind behaviours, impeti, lifestyles that give voice to the self weakness. The patient that restores his Self is less dependent from the object, he re-establishes a sufficient functioning, the severity of the symptoms can melt. Above all the treatment want to act upon the possibilities of the subject to rely on his Self and upon the birth of the first grounds for a more flexible and less weak personality structure. The patient improves the property of his "protective screen" and this allows a stronger effectiveness of the contemporaneous or following treatments.*

The GRF, born for addiction treatment in a centre for addiction (Cart di Milano, Zucca Alessandrelli), is a device that is placed among the traditional dynamic-oriented group-therapy and the time-limited therapy**.**

In the GRF psychoanalytic interpretation is not used, and leaves deliberately on the background the conflict with the therapist and the most primitive conflicts, discouraging the outcoming of a generational transfert that would be an impediment to the peer-group job. This characteristic is innovative and distinguishing.

It mainly works with a focal purpose upon predefined topics: the focus of the group is on themes of narcissism and addiction.

We underline that GRF is originated as "an existential experience of growth" as the author Zucca Alessandrelli supports: this device is to discriminate from the other group psychotherapies.

The GRF sets as a mean for the rehabilitation of the growth process and consequently of self functioning. The distinctiveness of GRF consists, as told above, in ascribing weight to the peer group, in favouring an active conduction style of the therapist, in using time factor as a stimulus to improve change.

The GRF-p is structured in a predetermined time group of 35 weekly sessions of one hour and a half each.

The characteristics of the group are explained to the participants before the beginning of the group: in a series of 10

preliminary interviews, that have the aim to give the patients a familiarization about the themes of narcissism and addiction and about the association between these foci and their personality. Before the beginning of the GRF-p, patients are asked to sign an informative form, a kind of contract: this happens during the last individual interview, and the contract contains the main rules to respect (punctuality, no-physical aggressiveness, times, duration) and the main themes that will be dealt. We think that sharing these information is appropriate for these patients, because the introduction of the project means to give the patients a realistic and comprehensible task, allowing them to face a "journey" characterized by a reasonable unsaturation and by a less threatening emptiness (this aim is obtained also through the predetermination of the duration).

Rules sharing can help to support the participation of the ones who are afraid of an improper use of the communications inside the group. Contract is functional to the treatment itself, because it discourages the use of "safety devices" (according to Trentini those less evolved defences that patients act if they don't feel sure) and it encourages the emersion of the neurotic defence mechanisms, that will be object of the therapeutic treatment.

The sign of a written document increases the value of the responsibility both of the conductors and of the patients who engage each other in a care project. Responsibility is not limited in a mere formality, but it rather puts participants in the position of active subjects and it increases the value to whom suffers from a low self-esteem; this sign allows these patients to perceive themselves as people considered inside a healthy relationship.

Group for psychological functioning restoring uses the so-called "interpersonal cushions" personified by the group of the peers (the fraternal group). It has the aim "of the third", that mitigates the transferral tension with the therapist who already discourages the generational transfer (through this specific treatment).

The cohesion process is eased, from the beginning, by the homogeneous composition of the group. Concerning this, we believe it's important not to think about homogeneity as something that simply belong to a diagnostic dimension, related to a life phase or to objective and indisputable life-events. We mean a homogeneity in a heterogeneous context, as it's a CPS : homogeneity is a characteristic that the therapist recognizes in the common addiction of the patients. This way homogeneity is much more a therapeutic factor than a stigmatizing equality. The admittance of homogeneity quickens and simplifies the cohesion processes.

The GRF makes use of the identification of a focus that is made clear to the patient through comprehensible themes: focus is on narcissism and on addiction. The specific themes can be selected are: shame, touchiness, low self-esteem, craving for the object, the difficulty in recognizing the own Self and the consequent effort in taking care of it. These themes are clearly and intelligibly discussed with the patients. The predetermined temporal limits shows its therapeutical efficacy in the ability of seducing (by leading to self meaning) patients who are afraid (because of their weak identity) of the possibility of con-fusing, and consequently of fading.

When we offer these weak patients the chance of a tolerable experience, this immediately acquires the peculiar value of a thought (a gift) with a strong empathetic significance. We don't make this explicit, for it could result humiliating for the patient: we will simply propose the treatment as he can idealize it.

The patients who arrive till the end will benefit from the evidence of their ability to conclude their "journey" (strange and not usual experience in their lives). These patients are persons who have seldom been affectively fed during their infancy and early childhood.

This kind of group can become an enough sufficient good tool (as Wiinicott would say) thought by a therapist with a low conflictual rate, but with a great empathetic capability. A good enough therapist who can give their patients the presage of a loving, non-judging and non-devaluing superego.

The concept of "care-episode" is also used by Linehan in her model for borderline disorders (Dialectical Behavioral Therapy) that is considered the standard model in that diagnostic field. This only to underline that literature is dealing with the drop-out problem, so common in patients with a borderline disorder or with an severe Self weakness.

We underline that also a treatment that originates from the psychodynamic thought can be suggested for a predetermined therapy, thanking those correctives that help weak patients.

The drop-out of the weak patient needs to be seen as an expression of the necessity of the subject to keep the distance, to escape in order to find his way in a second time.

The temporal limit establishes from the beginning a deliberate and propulsory vector to individualization processes, as many other authors remind us (for example Corbella). It concerns the time- realistic register, instead of the eternal-maternal one with an almighty connotation.

A device like this one (in a synthetic way for matter of space) already considers to predispose the right distances (through the peer-group, the focus, the predetermined duration) and create a protection towards the drop-out. We have to underline that these patients think their abandonment in a guilty way: this leads to increase their sense of guilt and shame, that can affect their capability of looking for a further help.

The aim of GRF is to allow the patient to recognize himself as a worth person, and consequently to recognize himself

as a subject and simultaneously as an object in a relationship.
This happens through a complex and skilful conduction that eases the activation processes of an intermediate thought (that the therapist has to induce through proper intervention or with proper silences). The therapist discourages magic, almighty, autartic thoughts in order to promote a realistic thought, the admission of the own value as an expression of potency, the group symphonic thinking, where every participant can help the other to recognize parts of self and to get in contact with them.
As we see the common characteristic of these patients in their addiction behaviour, we can think about a diagnostic range of the addiction for the coming classifying manuals. Many American psychiatrists ask to pay attention to the need for considering the dimensional consideration of personality. For example when comorbidness is not simply the co-presence of symptoms, but it's the expression of the same complex disorder at a mental level.(Psychodynamic Diagnostic Manual).
In line with the idea of "favouring the direct clinical experience instead of the metapsychological dimension, above all if the latter is lacking in an empirical research support" (Rossi R., Rosso A.M. 2007), the language used by the authors of PDM is never barren psychoanalytic, but fit to the empirical evidence, descriptive and easily utilizable in clinical observations by multidisciplinary equipes.
The interesting suggestion that originates from this idea is the possibility to get out from the old dichotomy biology/psychology and to reintroduce psychoanalysis over the crisis that, as Faimberg (Rosso) asserts, belongs not specifically to psychoanalysis, but to some psychoanalysts.
A peculiar interesting remark for our topic is the Rossi and Rosso's one who, dealing with PDM, say that "a classification system built on these assumptions could have the secondary effect of reducing treatments symptoms or behaviour focused that turn out to be ineffective". The authors cite as an example the contraposition between a diagnosis of a panic attack disorder and the observation in the same patient of the chronic and disabling incapability in giving an appropriate answer to the emotional signs coming from the external.
GRF, if applied for the treatment of both drug addiction and other kind of addiction, discourages patients in concentrating upon symptoms (the detail): it tries to shift the attention upon the common substantial. This approach allows to influence in a more effective and lasting way upon the personality structure.
If we follow the direction of PDM, the observation of our patients should emphasize more the personality structure rather than the symptoms the patients bring to us.
We should underline the quality of the object relation, the capability of affect tolerance, of defence mechanism, of coping strategies, of a good reaction to stressing external stimuli, and so on.
We should not need this new manual to agree about the necessity of a clinical approach that bears in mind of personality structural elements.
The evidence of an excessive fragmentation and of a fruitless attempt in giving different replies for any different symptomatic manifestation underlines the need of different tools (especially if we consider long-time results).
This doesn't regard psychosis or severe mood disorders where nowadays psychiatry can give effective care. The problematic area regards those patients in a border and psychologically disturbed-neurotic range who reveal themselves in a polyform way.
Because a great part of these patients has difficulties linked to their weak narcissistic structure they develop an addiction: pharmacological solution can give a support but it cannot be resolutive. Psychoanalytic therapies can be unsuccessful, because of their transferral burden and of the unbearableness (for these patients) of the interpretation.
Group, and mainly a time-limited group can be the elective suggestion.

CONCLUSIONS: ANTONIO'S CASE, SECOND PART.

Every reader, if he paid attention to this article, could have thought about some of his patients suffering from panic attacks, with preceding problems with the own corporeal image or polyaddicted to light drugs (or these three characteristics together); either we could think about some young patients who get in crisis because of an amorous parting, in consequence of a job failure or of a clash inside the family: usual events that can at first sight not seem important.
This kind of transnosographic is the one we more care about, because it's the more misunderstood and barer. It represents a wide range of patients who ask for help in territorial services.
We saw at the beginning what it means to recognize addiction problem for therapeutic prospects: it means to recognize an eager need for objects, a deep emptiness and a lacking Self.
We don't mean to deny the importance of conflict, but we want to underline that this can stand in the background and that it doesn't have to break into the therapeutic relation too precociously.
When the subject, some time ago, felt the object cry upon which he could counterinvest in spite of effective

identification processes, he weakened his interiorization capability, passing to exteriorization processes. (Jeammet)
The symbolic mental representation chances are as much weak as the investment upon the outside is premature. In this way possibilities of a healthy growth in a neurotic sense decrease: why should we involve symbols in the therapeutic process, if symbols are lacking or even seriously absconding till to include those subjects I defined "without psyche"?
Only if we are able to discover a representational mind , the patient will accede to psychoanalytic therapies. If this kind of therapies will be indicated.
Otherwise it's better for these patients to stay inside those devices that allow him to find the lost way, sometimes even starting from a good équipe we can set the basis for this treatment (Jacobone, Carraro, Ricci).
In this sense Antonio becomes an illustrative case, independently from the intrinsic severity degree and from his kind of distress. These patients come to the services when addiction becomes a menace for their narcissistic "steadiness". They can consequently show those symptoms that we describe as changeable and fickle.
Antonio can hide himself in a swift "recovery" through some strategy of object counterinvestment; or he can fall a prey to narcissistic depression or to the breakdown menace through a severe anxiety shown as the need to control or the fear to loose it.
What should we plan for and with him? It's a recent case: we still don't know how it will develop. But we know how we can support him and that we cannot awaken prematurely some parts of his conflicts.
We can try to set the therapeutic distance: both in the pharmacological prescription and in the possible psychological treatment.
The patient with addiction problem has the vague hope that the therapist can go beyond to what he says, as Jeammet affirms telling about an anorexic patient. The patient hopes this but, at the same time, he hopes the opposite; he wishes to be understood, but not to be bereft of a part of himself. The price to pay is emptiness.
We can see a necessity to be "forseen", but at the same time the fear of being transparent. This patients wish that "the others become the mouthpieces of a desire that the patients cannot recognize by themselves" (Jeammet). At this level the GRF-p operates: the therapist recognizes the patient, his needs and prescribes skilfully the experience that the subject needs. The GRF-p can answer these questions. None ever thought about this patient in this way: now we can. He will be grateful, in the same way that most of the patients we treated with this device have been.
This peculiar attention is for-give.
Antonio is a gambler (he also gambled on the Stock Exchange), he loves more excitement than winning, that moreover seldom happens.
We don't believe he needs forgiveness but he needs the gift of the sense of what it's happening to him. He describes us as his behaviour is out of control because of the ceremonial and because of the sensory excitement that this behaviour raises (the psychic substances that Zucca Alessandrelli and his équipe talk about).
Antonio has a Romanian partner who complies with him; a partner who seems to give importance to money and to a certain lifestyle, but she asks him neither to become father nor to become adult. They live in the old parent's house.
Gambling oblige them to stay far from gaming houses, because of the debts; consequently emptiness, the loss of the object that supported the magic effect of the expectation, the anguish begin to be manifest.

SQUARE 8. ACTIVITY DATA.
***Duration**: from 2005 to 2008*
***Number of treated patients**: 22, 8 males and 14 females.*
***Age band**: from 20 to 48*
***Drop-out**: 2 males*
***Patients with previous admission in a psychiatric ward**: 3*
***Patients who passed through the emergency unit**: 5*
***Patients with a pharmacological treatment**: 11*
The effectiveness of the treatment has been assessed also through the administration of scales (SCL-90) and test (MMPI-2 and Blacky) in order to collect some more information about the subjective symptomatologic levels (of personality and intrapsychic). These instruments have not been considered as diriment for treatment efficacy, because of the difficult in having a sample shareholder: they have been useful to draw some further information that can be added with the information of the final interview and of the treatment. We can say that almost all of the patients who finished the treatment had an improvement in the restarting of their social activity and in their relationships: we also noticed a lower symptomatologic severity and in some of them the resolution. The patients, who had had a passage in ward or in emergency unit, did never need it anymore; about the 70% of who had a pharmacological treatment take no more medicine. The rest (3 people) is now followed with psychiatric interviews. Two patients asked for an

individual treatment.
Antonio started the first interviews in order to get into the group.

Complexity of human being seems extra ordinary from the psychodynamic point of view. Everyone has to be seen as a person formed by many instances. It could be interesting asking why Antonio began gambling and why he didn't become drug addicted. The reason of this choice. Here comes out, sleepy but not silent, the reasonable motive: the conflict. The one we can indicate as the main scenarist on the stage of addiction: in this way I personally join the theory of conflict with the addiction one, the diachronic vertical with the synchronic horizontal.
According to Freud, the gambler would find a sort of masochistic relief: he would aim to play especially when he is losing, because he is driven by an unconscious masochism that allows him to balance the sense of guilty moved by the desire to kill the father. On the Oedipus background of the scene, other authors (Fenichel for example) see the desire of self-punishment and compare gambling excitement with masturbatory pleasure (Lavanco, Varveri).
So we notice, in Antonio, the image of an undervaluing, suppressive and intrusive father; and a "wall-paper" mother, an undifferentiated container. Antonio tells us that he began gambling in 2000 (I think after his mother's death, but he cannot think about this connection).
Antonio is waiting for, more or less covertly, his father's death to have the possibility of living with his partner and perhaps to allow himself that sense of freedom that frightens him because it's full of almightiness, of magic, with no limits.
He doesn't admit this: I do think it, but I don't have to tell him: Antonio's narcissistic weakness advice it against on first instance.
So I think we can think about an addiction psychopathology that deals with human being's different instances: we have to accept complexity and to look for a way that allows to all these psychic subjects to communicate each other and to relate each other through awareness, that is the essence of a healthy person.
In conclusion, I would like to answer to those who say that addiction problems have always existed: this is true. But we can see an increasing number of cases if compared to the classical neurotic monosymptomatologies. This is caused also by the new sociocultural references of the so-called western postindustrial civilization. But some of the nowadays weak passions ever existed: when we talk about new patients, we are not talking about a new phenomenon but about a new way to approach to the phenomenon.
Perhaps we should consider much more our own need of sensorial excitement, through risk, sexual transgressive pleasure, pleasure and risk linked together when one takes drugs: in those seconds or minutes or hours (but the true substance is the ceremonial) we can notice a moment when the self will be clear and, even if fallacious, authentically adulterated. In any case it is not sufficient to allow the subject not to repeat a ceremonial that can take the subject to increasing sufferings.

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- clinical job in CART-study center (www.cartonlus.it), Milan, Str. Montepulciano n. 13;
- application of GRF: Dr. Andrea Giannelli (giannelli.cps@libero.it) c/o CPS, Milan, str. Fantoli n. 7 (Policlinico Mangiagalli Regina Elena Foundation, IRCCS-UOP 45)

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