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Section “Traces” of the journal *Psicoterapia e Scienze Umane*

Edited by Pier Francesco Galli and Alberto Merini

*In this section of the journal *Psicoterapia e Scienze Umane* we present previously published or unpublished material in an attempt to retrace a sort of history of psychology, psychiatry and psychotherapy, at times with the emotional power of anecdotes that usually do not appear in academic historiographies. The analysis is developed along three fronts. The first is an analysis of the various psychoanalytic stereotypes in their declinations and the manner in which theory of technique was passed down; the second is a reconstruction of parts of the history of our field in Italy, within the framework that has always characterized the group of *Psicoterapia e Scienze Umane* [“Psychotherapy, Humanities, and Social Sciences”]; the third is a reprint of “vintage” articles relevant to the current debate. At the web site <http://www.psicoterapiaescienzeumane.it/traces.htm> there is the list of all material published in this section.*

Psychiatric training: a first chapter.

Giovanna Gallio holds a conversation-interview with Pier Francesco Galli

Introductory note

Giovanna Gallio, within the framework of research on “Goals, Needs, and Methods in Mental Health Training” by the *Study and Research Centre for Mental Health* in Italy’s *Friuli-Venezia Giulia* Region, asked to meet me in September 1999 to discuss my experience in the field, and in particular to reflect together on the situation in the *Friuli-Venezia Giulia* Region, considering my significant experience working in that area. As one can observe, the manner in which Gallio poses her questions bears witness to her ability to seize and then develop a problem’s essential elements, creating a space in which the interlocutor is able to provide lucid and concise answers. The clarity of the exposition is thanks to her. It is a duet rather than an interview. The material has not previously been published and was brought to our attention by Paolo Migone during a meeting with Giovanna Gallio. The decision to publish it is the prelude for other papers on the subject of psychiatric training, a subject that is both outdated and very current. For me it has been the mainstay for most of the work I am still active in. A number of moments are enlightening. As far as training is concerned, the world of psychiatry is also a metaphor for the problem of “training” in the medical sector, and more in general in the public-private debate in Italy. This is an extremely current issue, and I spoke at a session devoted to this in the series of theme conferences organized in Rome by the Health Ministry on July 11, 2007, and coordinated by Dr. Marco D’Alema (the title of the conferences was “Processes of research, promotion and protection of mental health in Italy today”). These are long-standing problems that continue to afflict us. In the section “Traces” of the following issues of *Psicoterapia e Scienze Umane* we will see a reconstruction-construction of the vicissitudes of projects and implementations so as to outline, in a backlit manner, a story with which many will identify.

Pier Francesco Galli

Giovanna Gallio's* conversation-interview with Pier Francesco Galli**

1. Introduction

Giovanna Gallio (G.G.): *I would like to discuss with you the requirements and methods used in psychiatric training and the role it plays in the current stage also following the corporatization of the health sector. This is the object of research undertaken in the Friuli-Venezia Giulia Region, where a very advanced reform bill has not been sufficient to create a homogeneous mental health systems between the various areas over the past twenty years. The development of a regional framework in planning policies has been blocked by many factors that should be analysed in depth, but also by rivalries and prejudices that now seem to be attenuated by a greater level of agreement between those responsible for the Community Mental Health Centres (CMHCs). For many years, before and after the reform, you have spoken on training and supervision in the Friuli-Venezia Giulia Region, so I consider your opinion to be especially important. What was your experience when working in the Region?*

Pier Francesco Galli (P.F.G.): In spite of the at times intense conflict concerning theoretical ideas and political customs after the 1960s, there is still a relationship of great respect and reciprocal esteem between myself and the psychiatrists who have worked in Gorizia and the *Friuli-Venezia Giulia* Region, proving that one can be critical, but that at the end of the day we are all on the same side. It is a relationship that has lasted even with those who at a certain point left Gorizia to go and work elsewhere. I remember, for example, that in the 1970s Antonio Slavich first summoned me to Ferrara and then to Genoa, with the task of carrying out a very difficult job in the psychiatric hospital there. I also held training courses in Turin during the 1980s, when the director was Agostino Pirella. As far as the *Friuli-Venezia Giulia* Region is concerned, even before Bill 180/1978 was passed, I had begun to work in Pordenone with Enzo Sarli, and later continued to work with Angelo Righetti. Generally speaking, one could say that following the approval of Bill 180/1978, those adhering to “front line psychiatric politics” – especially in *Friuli-Venezia Giulia* – and committed to move beyond the existence of mental institutions, were slower to accept the idea of specialist training. In the midst of that battle, throughout the 1970s, training was generally neglected. It was only half way through the decade, after 1976, that educational needs became part of specific research projects coordinated by the National Research Council's Institute (*Consiglio Nazionale delle Ricerche* [CNR]) of Psychology, directed at the time by Raffaello Misiti. Later on, there was a very brief period during which the ideology of the “single operator” triumphed, with all the organizational inconvenience this caused which later emerged very clearly. An intellectual can put his privileges at stake at any time by assuming a lower role within the hierarchy, but the same does not apply to operators. It was only after that rather confused period that more organized and systematic attempts were made in programming and organizing training.

In particular, in 1989 I was consulted by Angelo Righetti who had obtained funding for training nurses. This led to the idea that a school of psychotherapy should be created, consisting of an extremely well organized four-year course, characterized by a strong impact of both methodology and the kind of culture to be transmitted at all levels. This training was provided, so to speak, “in the field” within the context of services provided in Pordenone, but was open to operators from the entire Region – whether graduates or not – by enrolling and paying a small fee. This experience was a success with high levels of enrolment and the school was attended by 25% of the Region's graduates, psychologists and medical doctors. Nurses were trained separately in an extremely well-organized context, alternating classes with debates for small groups, applying listening and case discussion methodologies. Mental health care providers came from all local health centers and only Trieste, to a certain extent, refrained from joining this initiative.

* Via Guglielmo Marconi 26, 34133 Trieste, Italy, tel. +(39) 040-635685, cellular phone +(39) 349-7635335, E-Mail <giovanna.gallio@fastwebnet.it>.

** Via Garibaldi 3, 40124 Bologna, Italy.

G.G.: *In that context you had a vast regional observatory and were able to collect a great deal of information concerning the variety and diversity of operational methods. What were your perceptions?*

P.F.G.: Leaving aside all the conflicts there may have been, and the differences of opinion or divergences you emphasized earlier, my perception is that *Friuli-Venezia Giulia* is still the most avant-garde Region in Italy. It is the cornerstone in both psychiatric training and above all practices. In spite of the problems experienced by this Region during the 1990s, I continue to observe a high level of motivation among mental health care professionals, thanks to the strong culture gained during the years of the transformation of mental institutions. Although not yet formalized, nor do I believe it ever will be, this culture remains widespread and continues to nourish a very elevated motivational potential.

G.G.: *Let us address this point; the importance of motivational systems in psychiatry and the effects of the corporatization process.*

P.F.G.: This is an aspect I have discussed and addressed on many occasions over the past ten years, long before the effects now becoming visible¹. We know that in psychiatry 80% of procedures occur in informal daily routine, as do decision-making processes. This means that the quality of work is based on mental health personnel's motivations. It is by bearing in mind this aspect that one can observe the negative influence of so-called corporatization, which is not, as instead portrayed, a "reorganization of services." In this field one must always differentiate between the buzz words and real efficiency, so much so that matters are coming to a head and those who until recently made statements about great changes are now falling silent. What did this process involve in recent years? Firstly institutional command became administrative, taking power away from those with expertise. It is no coincidence that the level of arrogance in administrative communications and service regulations has greatly increased, with an intermediate managerial group that is really in charge instead of those appointed to managerial positions, putting pressure on mental health care providers.

This "administrative block", as we call it, is a chain of command with very high levels of stagnation, so that the other managerial chain, that until a few years ago was the driving force, now seems greatly weakened, lacking. Mental health care professionals have simultaneously been subject to enormous frustration, especially the lower operational sector consisting of nurses. In strengthening the elements of criticality, this becomes entwined with changes made to the personnel recruiting systems used by local health authorities. Increased employment of younger staff applies to the nursing sector and, unlike what happened in the past, those entering at higher levels are aged between 35 and 40. These are people who have already experienced life and are less ready to make a motivational investment, with a reduced time space of discretion and a very low willingness to run risks. They in fact have mortgages to pay, family expectations to satisfy and so on. Therefore, over the past decade, we have lost the conditions for maintaining an ideal motivational level for identity. In spite of this, the ideal emotional level spread by Franco Basaglia [the leader of the de-institutionalization movement in Italy], starting in Trieste and even before that in Gorizia, continues to remain high in *Friuli-Venezia Giulia*. Obviously here too there may be many members of staff who complain, but one must distinguish all that is said in controversies and verbal clashes from the real motivational approach of individuals.

G.G.: *You often say that what matters in psychiatry in terms of working conditions is "institutional voluntary work". What does that mean?*

P.F.G.: It means that while in surgery, for example, the procedural obligations are very well defined, in psychiatry they are not. No one can oblige you to play the guitar at a Day Centre, even if you are a good musician. No one can demand that you be obliged to comply with a given procedure. But it is preserving a high level of motivation that is today's issue at an educational level, as is the

¹ See for example P.F. Galli, L'aziendalizzazione nei Dipartimenti di Salute Mentale. *Psicoterapia e Scienze Umane*, 2006, XL, 1: 87-94; P.F. Galli, L'epidemia della normalità: dagherrotipo del nuovo che avanza. *Psicoterapia e Scienze Umane*, 1998, XXXII, 3: 5-9. Internet edition: <http://www.priory.com/ital/180/dagherro.htm> (paper presented at the International Conference "New Trends in Schizophrenia: Ten Years Later", Bologna, April 8, 1998).

development of managerial and leadership capabilities. Further conflict currently derives from the fact that some professionals have now become “directors” and “service coordinators”, while until recently they were equals belonging to the same generation and age group. It is hard for these people to be acknowledged in a leadership role and as being capable of managing others through delegating. This rarely occurs. At times those who play their cards well manage to involve others, but in many cases this does not happen, which leads to conflict.

G.G.: *The leadership crisis in the corporatization process is linked to the allocation of power from the exterior, from above, rather than from within the groups...*

P.F.G.: This is another critical aspect. Leadership is totally separated from the operational level and from real work groups. Directors wander around offices, they are not qualified to practice and therefore not well-accepted or not accepted at all. Real operative management, provided by those who work, is second level management.

G.G.: *In your opinion, is it this class of management that feels excluded and alienated from the decision-making process?*

P.F.G.: Paradoxically it is not second-level managers who feel alienated, it is the head manager. Since things must get done anyway so one must continue to work after experiencing a period of frustration, since “mad people” must be treated if nothing else in order to survive within their own identities. In psychiatry, identity is not linked to doing, but to being. Even if you do not succeed, you do what you have to do anyway, in order to survive. You do so even if burdened with great frustrations, in a situation in which demotivation, paradoxically, becomes an element of survival. If you are responsible for the operating instruments, time may be short and the sequence may change in the operating theatre, but you do your job well because the procedure is a certain one. In psychiatry, instead, if you do not act you do not exist, you are not. Hence a negative leads to motivation to take action that is, however, taken in order to survive.

3. *The culture of organizational management*

G.G.: *In speaking of this are you referring to real cases in which you have been called upon to resolve conflicts?*

P.F.G.: Dozens and dozens...

G.G.: *In interviews linked to this research, many debated the evolution of the team and the change to the very meaning of “team work.” It is not just the operational system that has changed, or the way of working. Even “consumers” have changed. The problems encountered in developing new leadership are made to coincide with a crisis of competence involving almost all professions, new scenarios in organizing the Regions following corporatization. For example, in the relationship between services provided in the same area, a culture of organizational management is now required and is put under pressure in all professions as an ability to define procedures for achieving given goals. There is hence a decline in the degree of omnipotence of territorial psychiatry, which in any given district is obliged to take into account other players, bringing to life the network of other services with which it is necessary to cooperate. There are many variables that must be considered within the framework of this analysis, inducing us today to speak of a transition and the crisis experienced by operational models. This is a crisis that could evolve in a regressive and demotivating way, but could also coincide with a fair feeling of bewilderment; a disorientation inducing one to reformulate work styles on new bases. In this sense it could become a phase of growth and development in rethinking previous organizational models.*

P.F.G.: I do not in fact want to underline negative aspects of this analysis, but prudence demands that before stating that the “new system” means growth, we should see how it is implemented. So-called “organizational culture”, or organizational management, is a spurious culture in the health sector. It is not really a corporate culture in spite of adopting a “business model.” Hence the educational criteria for organizations, adopted to address this phase, for example sending people to the *Bocconi University* to increase their business management capacity, seem to me, to say the least, badly assessed in terms of “power” and not of “powerfulness”. What chance do these managers

have of applying what they learn about organizational management, when the ability to manage human resources is an experience lacking in this kind of training?

I believe that this is the defective turning point that should be re-addressed. While increasing verticality in organizing community mental health centers could have marked a real step forward, it has instead involved the emergence of the leaders' personalities as the most determining factor. If by chance you have a pathological manager you are finished, everything is stopped. So real managerial skills, the ability to manage human resources, in some areas has worked only thanks to the personal characteristics of those appointed; in other areas it did not work for the very same reason. In many cases the person was appointed to manage services and departments was someone who, since he/she did not have the ability to work as a psychiatrist, but did know how to use a computer. It is often these people who nowadays become managers. Another aspect is that within the reality called "a company", it is the company that dictates the goals. In this context even a manager loses power, since he too is in turn burdened with imposed objectives, all the more so since these are objectives almost always established within the framework of economic reasons and savings to be made. There is a lot of talk about budgets, moving investments from one objective to another, reducing expenditure, but that is not the real criteria for savings. Real savings are made on a program for the company's future and its survival, not purely on savings on an accounting basis. Seeing that the accountant-based logic prevails in many cases, the real price for corporatization is paid for at an operational level. In this sense there is no saving, but an attack on the mental health professionals' motivation. That is why I earlier mentioned "institutional volunteer work". We need a motivational system that will need to be totally rebuilt, but that would involve a resource that has been discarded. So, it is not that one has been given a certain resource, halted for a certain period to then be applied again. It is a resource one has allowed to decrease and that one will have to rebuild. This is the trap into which health services have fallen and have started to understand that if they do not recover the consensus of mental health workers, then nothing can be done and there will be no development.

4. The renewal of human resources and motivational potential

G.G.: *I would like to return to the "spurious characteristics" of the health services' organizational and business culture. You have said that management culture has for now been applied to managers in the form of training, in a mechanical manner, copied in a more or less innovative manner from business management models.*

P.F.G.: ...not at all innovative, that is the point! Health services have been sold a management model that was already twenty years too old for normal production companies. "Toyotism", as an advanced form of management, is based on the assumption that the quality object one intends to produce is not so important because of the plastic or gas used, but because of what a person has put into it, without separating matter from the work. In more advanced management models that is what one aims for; the involvement of total responsibility.

G.G.: *Business management has for some time understood that the real issue is the renewal of human resources, while – in your opinion – the health services have been sold an old management model that totally neglected the renewal of human resources, the importance of which is all the more essential in psychiatry.*

P.F.G.: Yes indeed. To this one must add another restriction, the fact of moving towards the so-called "private social sector" a significant amount of intervention – reducing services both in number and above all as far as assessment criteria are concerned. All this has been very humiliating for our human resources, since assessment criteria are no longer centered on the process but on quantity. This is simply a mathematical criterion! In my opinion this reveals an inability to analyze the product. Now, in one way or another, in Friuli-Venezia Giulia levels of motivation have remained very high...

G.G.: *And you believe this is the result of a previous background...*

P.F.G.: Certainly...

G.G.: *However, the analyses I collected throughout the Region revealed a great deal of dissatisfaction, limitations that are expressed. How do you judge this unease?*

P.F.G.: This may indicate to what extent people are frustrated and to what extent – in that Region in particular – they have had to deal with another very influential aspect: the extent to which a charismatic leader can motivate and inspire. In the past, much impulse derived from idealization, from the force of a magnificent personality inspiring the battle against mental institutions. Such elements cannot last for forty years, and hence everything that happened afterwards is perceived as retraction, to the extent that this perception results in underestimation of real efficiency. These are factors arising from pure social psychology.

5. Teaching or training? Specializing in psychiatry

G.G.: *One has the feeling that in many cases what is stated does not correspond to the results achieved...*

P.F.G.: As a trainer, here in Bologna, in Genoa or elsewhere, I come into contact with many groups, hundreds of mental health care providers every month, and therefore one can imagine not how much I teach, but how much I learn about their work. The point is to make visible to mental health care providers what they do, confer logical meaning to what they do, even if they are unaware of it. In my opinion that is real training, not teaching or “studying subjects”. Teaching – in the sense of “studying subjects” – is delayed education, not “training”. It means teaching at a later date what has not been taught before. That is the result nowadays of incorrect didactic and pedagogic systems that are not linked to jobs. The important crossroads we are at today is the fact that while before one had access to both state and private sector jobs, passing through experience (a graduate quickly accessed jobs through the hospital), while now the labor market is entirely in the hands of universities, and this is an enormous contradiction.

G.G.: *I am glad you have brought up that subject, the reform of psychiatric residency training, i.e., specialization schools. In the past, young psychiatrists undergoing specialization training went to work immediately after graduating, either directly in a hospital or in a community mental health center, while now they remain sequestered in the hospital.*

P.F.G.: They do, and it is absurd.

G.G.: *It seems also very illiberal to oblige people to remain in a hospital accepting the income offered, they instead should be approach reality, expanding their ideas and searching the labor market for a chance to create a life.*

P.F.G.: That is exactly what happens. Schools today provide instruments that those professionals may perhaps be able to use in ten years' time. This issue must be emphasized because otherwise the new recruiting systems make no sense. This too is a subject I had addressed ten years ago in an article published in the journal *Mondoperaio*², where I stated that the next generation would enter the workforce aged forty, by which time they are already burnt out as far as motivation is concerned. After completing their studies, they will have brief jobs or work freelance before becoming gainfully employed and once again years will go by. Directors will be quite elderly and these young people will have to make do here and there once they complete the process allowing them to access competitive examinations. It is like that everywhere, everyone is getting organized. While they specialize, they form a group of, let's say, three, and open a private practice because there are no opportunities in the national health service. Those who do access it, will be those for whom university selection has worked, the “good students.” For better or for worse, in other clinical sectors after five years one has learned to be a surgeon, or at least a doctor. In psychiatry, students remain sequestered in universities where they learn little, or perhaps nothing of what they will need. Some of them practice locally if the hospital they are attending manages parts of the Region; others instead are excluded from this and so have no experience whatsoever of what psychiatric work really means. The so-called biological-pharmacological and “diagnosticistic” culture has become

² P.F. Galli, Problemi della formazione in psichiatria. *Mondoperaio*, 1990, 43 (November): 52-54. Also published in *Psicoterapia e Scienze Umane*, 1991, XXV, 1: 7-12.

dominant in universities. This is the direction taken in the midst of psychiatric hegemony and on this basis there is not even uniformity in training. Once again we are speaking of how training is linked to motivational factors, and also about another aspect that constitutes 80% of our work: the interpersonal element. There is no uniformity whatsoever on this point among specialization schools. Due to some kind of informal internal agreement, there are some schools that say they teach psychodynamic psychotherapy, others teach systemic psychotherapy and others still teach absolutely nothing. That is how the hospitals control the labor market. So what kind of training should one aim for? Does one always plan something that will be useful in the future for training these psychiatrists who arrive without the training required for their jobs? At least apparently one does, because, effectively, interpersonal management, as mentioned earlier, is no longer situated within the health service, but as been delegated to the “private-social” sector (e.g., cooperatives). Who nowadays spends seven or eight hours with a patient? Young people working in cooperatives, because in the meantime psychology has been eliminated from the services.

6. Training psychologists

G.G.: *This is a subject I would like you to address...*

P.F.G.: Psychologists are now sequestered in schools. To do what? To obtain their qualification as a psychotherapist, a profession they will one day perhaps practice? In the meantime, if they need to earn a living they enter the labor world through the private social sector as community mental health professionals.

G.G.: *Furthermore, their professionalism is based on the medical model, as Gian Franco Minguzzi believed*³.

P.F.G.: It was just that if you told him that, he considered you an enemy of psychologists! I have always said that psychological competence does not coincide with being a psychotherapist in the medical sense. It is one of the things a psychologist can do, but a psychologist's real competence concerns groups. I was already writing about this in 1965⁴, when developing the idea of differentiating psychoanalysis' “therapeutic power”, which is very low, from its “therapeutic potential” which is extremely high if based on a group and the spreading of the interpersonal element.

G.G.: *Has the role of the psychologist not evolved in this sense in recent years?*

P.F.G.: No, I don't think so. Just very recently there has been the appearance here and there of a new role, and one finds many qualified psychologists working in organizational managerial positions, and four or five have become general director of services. They are still too few, but social and group psychology has never been the objective of psychologists who instead wished to model themselves on the medical profession. Even if one analyses events within an historical perspective, one sees the failure of the role of the psychologist as being “specific and different” to that of doctors. I am thinking, for example, of the extremely modern law on Family Counseling Centers drafted by the *Emilia-Romagna* Region in the mid-1970s, which placed group team work at the center. The psychologist's role was described as very important within this transversal group-based organizational framework. What happened? What happened was that the group disintegrated instantly. The gynecologists abandoned the Family Counseling Centers so as not to have to give up their hospital careers, and with the exception of those more politicized, most doctors accepted to work a few hours in the center to then return to their hospitals. Social workers in turn ended up

³ G.F. Minguzzi, La psicoterapia fra il privato e il pubblico (Interview by G. Gallio, Trieste, 1987). In: *Per la salute mentale / For mental Health* (Magazine published by the *Centro Studi e Ricerche per la Salute Mentale della Regione Friuli-Venezia Giulia*), 1988, 1: 91-98.

⁴ P.F. Galli La psicoterapia in Italia (paper presented at the Meeting of October 30, 1965). In: *Centro Studi di Psicoterapia Clinica*, editor, *La psicoterapia in Italia. La formazione degli psichiatri. Atti delle giornate di studio del 30-10-1965 e del 11-12-1966*. Milan: Centro Studi di Psicoterapia Clinica, 1967, pp. 5-21 (pp. 22-56: Discussion with interventions by Pier Francesco Galli, Mario Moreno, Franco Basaglia, Antonio Jaria, Franco Giberti, Giuseppe Maffei, Dario De Martis, Piero Leonardi, Edoardo Balduzzi, Giorgio Zanocco, Antonino Lo Cascio, Cesare Musatti, Cornelio Fazio). Internet edition: <http://www.psychomedia.it/psu/1965.htm>. See also: P.F. Galli, L'aiuto nella relazione: pratica clinica e prospettive teoriche. *Psicoterapia e Scienze Umane*, 2005, XXXIX, 3: 400-410.

doing only registration procedures, and effectively that was the end of the team. Psychologists who were greatly motivated at a political level (it was no coincidence that the entire group formed with Gianfranco Minguzzi worked in these services in Bologna), stood there empty handed and in the end the room reserved for psychotherapy became their refuge. Hence they ended up always reproducing the same model.

7. Training and professional paradigms

G.G.: *Could one say that, in general, training for psychiatry is not based on any professional paradigm?*

P.F.G.: I agree completely. Psychiatrists must have a variety of competences that cooperate and intertwine...

G.G.: *Professions should be prepared to have a very broad outlook, beyond the hegemony of just one paradigm, because otherwise it is always the medical paradigm that triumphs, which in psychiatry has been proved to be extremely reductive and unable to meet needs.*

P.F.G.: You are aware of the solution found in the United States and the attempts made to export it to Italy. As if to say “fine, our medical model is the only thing we can and must do as psychiatrists. The rest is care, move that over to social policies; it is not a form of knowledge that concerns us.”

G.G.: *In the Anglo-Saxon system, even in advanced social psychiatry, the psychiatrist is qualified to make the diagnosis and then... he provides the input...*

P.F.G.: The psychiatrist provides input about the only thing that at this point he knows, which is the diagnosis. In Italy it is not yet like that. In the United States the chain of command is and remains medical as the guarantor of insurance risks, and that is very clear. Since this is the strongest guarantee it cannot be diminished, otherwise who will run the risk? If you don't follow procedures you are finished, if you do something not envisaged by the procedures you are finished. Even the famous increase in pathologies derives from the fact that, in the United States, the insurance guarantees respect for the diagnosis made.

G.G.: *Are we moving a little towards this type of scenario?*

P.F.G.: That is the trend, but due to a series of factors Italy still maintains a culture of the interpersonal than cannot be annulled by high-ranking members of the professional hierarchy. This because of the years during which in Italy a culture of psychotherapy spread, becoming one of the ways in a which a psychoanalyst became a professor even at a young age, the reason for which this culture remains at an academic level albeit it in a few places. It is also and above all because of the power of Franco Basaglia's movement and Trieste as the driving force and the driving culture of reform. If interpersonal affairs are managed by the “private social” sector, and all services will be performed in the out-patients clinics, then we will return to the days in which Psychiatric Hospitals replaced the so-called dispensary.

8. Where to train: the Community Mental Health Centers' (CMHCs)

G.G.: *In many areas it is already like that. After Bill 180/1978, psychiatric care mainly continued to be provided following the out-patient model, and this was the great mistake. Undermanned, divided and fractured services appeared, with small rooms, limited competences, long waiting lists and so on. This is the model that ended up abolishing from mental health services the treatment of the more seriously ill patients, thereby delegating them either to no one at all or to Type A cooperatives. Returning to training, what I wonder is what would be the correct and most suitable way of providing that service today. A few years ago you had emphasized that in Italy there is a long tradition of having disassociated locations at which psychiatric help is provided from specialization centers. It is as if to say that even after Bill 180/1978, this disassociation remains and there is still a waste of the locations most suited for training, the Community Mental Health Centers (CMHCs)...*

P.F.G.: I had addressed this issue in the 1960s, when in planning training for psychiatrists one envisaged the activation for the first time of a real specialization center in Sondrio, in the Valtellina

(a valley in North Italy). In discussing matters with the director of that hospital we activated a program for a teaching hospital⁵, stating that the location chosen for training would also be the one in which psychiatrists would practice. It was a very detailed program, with over six hundred hours of training and students obliged to live in the hospital and work in the wards in the mornings. We had thought of doing the same in Pordenone with a center of specialization for psychotherapists...

G.G.: *You have stated that these could be the models for the requalification of the most suitable locations for training. All this would require the courage to open specialization centers where psychiatry is practiced...*

P.F.G.: But no one will ever do that! Community Mental Health Centers (CMHCs) could be the centers in which training should be promoted and invested in, but that is not the case.

G.G.: *All the more so because every time new nurses and young psychiatrists arrive, Community Mental Health Centres (CMHCs) are obliged to start the training process all over again.*

P.F.G.: One brilliant colleague who manages a recently-opened day-night psychiatric center in Reggio Emilia in which billions have been invested, told me that she was sent thirteen nurses from other medical branches such as radiology, surgery, etc. These are excellent girls, who, however, after working one hour in the morning and giving an injection, say, "and now what should we do?" These are nurses with excellent interpersonal skills, who have no idea how to consider these skills if not as a waste of time. The point is that nowadays so-called specialization for professions set up in Italy only follow bureaucratic procedures, providing a certain kind of technical culture that is not at all suited to the job to be done. This does not mean that there should not be specialization centers, but it is evident they provide a separation in subjects linked to learning certain procedures. In the field of psychiatry the training issue is different. Either training is organized by the Community Mental Health Centers (CMHCs), or there is no way this problem will be solved. There are few departments that are enlightened as far as training is concerned. Luckily we have Franco Rotelli or Peppe Dell'Acqua, in Trieste, who may also have different ideas regarding training. The point is that either there are centers like that or no progress is made at all. Luigi Ferrannini tried in Genoa, but it is extremely difficult. Community Mental Health Centers (CMHCs) are very diversified centers of power, with head physicians and universities. The Regions no longer have the funds for training and local health authorities are obliged to find the money in their budgets. In *Liguria*, of the 800 million liras (about 450,000.00 euros) found for training, 750 million (390,000.00 euros) were spent on providing staff with English language courses and computer training. Hence only 50 million liras (about 26,000.00 euros) were spent on training nurses and psychiatrists and of these 15 million liras (about 8,000.00 euros) were spent to organize a conference, with the remaining 35 million liras (about 18,000.00 euros) allocated to me, effectively the only tutor.

9. Training concepts: supervision

G.G.: *I would like you to discuss your ideas about training and in particular the methods you used. For example, in your opinion, what does supervision mean?*

P.F.G.: I start with a basic theory of technique in the psychoanalytic sense, according to which the so-called "predominance of interpretation", as the organized cognitive verbal form, is nonsense. What really has been done – what every analyst has done – has always consisted of many other things in addition to that. These are things that at last can now be said, and since the courage to express these matters has only recently appeared, they sound new, and that includes the problem of countertransference. My idea – which I consider original because I expressed it for the first time in

⁵ For a detailed description of this teaching hospital's program, see: Gruppo Milanese per lo Sviluppo della Psicoterapia, editor, *La formazione degli psichiatri nella situazione italiana*. In: Centro Studi di Psicoterapia Clinica, editor, *La psicoterapia in Italia. La formazione degli psichiatri. Atti delle giornate di studio del 30-10-1965 e del 11-12-1966*. Milan: Centro Studi di Psicoterapia Clinica, 1967, pp. 101-115 (pp. 116-136: Discussion with interventions by Pier Francesco Galli, Virginio Porta, Angelo Majorana, Leonardo Ancona, Giorgio Abraham, Montanari, Gianfranco Garavaglia, Giuseppe Mastrangelo, Franco Fornari, Mario Barucci, Diego Napolitani). This programme was also published at pages 10-14 of issue 1/1967 of *Psicoterapia e Scienze Umane*. See also: M. Declich, *Attività dei seminari di aggiornamentopresso l'Ospedale Psichiatrico Provinciale di Sondrio. Psicoterapia e Scienze Umane*, 1967, I, 2/3: 37-38.

1962⁶ – is that by separating the interpretation concept from organized verbal language, and assuming that conscious and unconscious interaction uses all communication channels, and therefore also non-verbal ones, one obtains a coordination of interpretative activities that are no longer interpretation, but achieved in the form of “continuous interpretive activity.” It is in this manner that one obtains – instead of extracting them as happens now – on one hand the interpretation, and on the other therapeutic factors. In this manner one obtains all that is called “therapeutic factors” within the intentions of interpretive activities. This means that the analyst, the psychotherapist, and the patient are not conscious of these things, but, and this is psychology’s clinical method, what confirms or denies matters is the *a posteriori* verification of the clinical assessment. It is *a posteriori* that one continuously assesses the clinical method applied to the human being: hence making predictions of information. Therefore, my way of working does not involve “interpreting cases” or “discussing cases”. Using my competence as a phenomenologist – a competence I developed practicing psychiatry in the old days, starting with working with psychotic patients and then with those suffering from less serious pathologies – my intervention consists in showing what mental health professionals really say they do, not what they believe should have been done. In other words, mental health professionals almost never feel they have the duty to report the best they have done, while you make them understand that what happens on a daily basis, moment by moment, everything they report and say they do is the most important element, because it is through this that they slowly understand how things work⁷. That is what I believe supervision means, not providing a little information about psychoanalysis telling what this or that means. It is obvious that I get on very well with the nursing staff seeing that my medical colleagues already have a mental and conceptual outlook of their own...

10. Training and conflict

G.G.: *Training is made possible by the creation of a place, a different place, thanks to the presence of someone external to the system...*

P.F.G.: ...outside the system’s conflicts...

G.G.: *...a trainer, who coming from the outside allows a sort of decentralization, a suspension, not an annulment of the contents of conflicts...*

P.F.G.: It is not a suspension of the conflicts, because in forming the value of knowledge conflict corresponds to creativity. Without conflict there is no creativity. Which are the goals one must achieve? It always takes time, but one must achieve them, and in pursuing these goals one must bear in mind that in psychiatry insecurity is a characteristic of the work we do⁸, not the manifestation of a lack of knowledge. In fact, no one can say or predict what will happen, but nonetheless one does things, one takes action. To repeat the usual example of the surgery room, the person responsible for instruments knows what to do, and is responsible for that specific patient. But when newly qualified psychiatric nurses visit a patient at home, they make decisions about a person that involve the entire context. The decision concerns the entire family, the nurse assumes a very high level of responsibility, necessarily linked to insecurity, because one has no idea what will

⁶ P.F. Galli, Fondamenti scientifici della psicoterapia. In: Gruppo Milanese per lo Sviluppo della Psicoterapia, editor, *Problemi di psicoterapia. Atti del I Corso di aggiornamento* (Museo della Scienza e della Tecnica, Milan, December 11-14, 1962. Papers by Gaetano Benedetti, Silvano Arieti, Pier Francesco Galli, Franco Fornari, Ugo Marzuoli, Berta Neumann & Virginio Porta, Mara Selvini Palazzoli, Leonardo Ancona, Virgilio Melchiorre, Tommaso Senise, Silvia Montefoschi, Enzo Spaltro, Fabrizio Napoletani). Milan: Centro Studi di Psicoterapia Clinica, 1962, pp. 69-80 (pp. 80-89: Discussion with interventions by Danilo Cargnello, Pier Francesco Galli, Leonardo Ancona, Silvano Arieti, Elvio Fachinelli). Also published in *Psicoterapia e Scienze Umane*, 2006, XL, 2: 203-212 (Discussion: pp. 212-220). See also: P.F. Galli, Tecnica e teoria della tecnica in psicoanalisi tra arcaico e postmoderno. *Psicoterapia e Scienze Umane*, 2006, XL, 2: 153-164.

⁷ See also S. Erba, P.F. Galli *et al.*, La supervisione psicoanalitica: lo stato dell’arte (Meeting organized by *Il Ruolo Terapeutico* in Genoa, January 22, 2005). *Il Ruolo Terapeutico*, 2007, 106: 7-43.

⁸ P.F. Galli, L’identità terapeutica nel regno dell’incertezza. *Psicoterapia e Scienze Umane*, 2009, XLIII, 1: 47-58 [A version of this paper was presented as Opening Address of the *10th Anniversary Joint Meeting della American Academy of Psychoanalysis and Dynamic Psychiatry (AAPDP)* and of the *Organizzazione di Psicoanalisti Italiani - Federazione e Registro (OPIFER)*, Milan, October 25-26, 2008].

happen and no one will ever be able to predict that. This results in the false success of psychopedagogies, giving an illusion of self-confidence. Things are done this way. Psycho-education is a list of normative attitudes that give people the feeling that they always know what to do, and also in the right sequence. But try and spend seven consecutive hours with a patient, the entire procedure becomes obsolete! You are no longer faced with a mentally ill person whose psychopathology must be reduced, but with a person who lives there, and so that daily routine becomes the supervision required to transform this life experience into professionalism. Ludwig Binswanger already said this in 1935⁹, and I used the following metaphor: You do not create the wind, you learn to use your sails, to take the helm. Nature creates the wind, and our job is to learn to sail. Well, what is our goal? The fact is that if one acts without self-confidence, and does not take into account the reality of the job – having to continuously make decisions feeling insecure – one's level of self-esteem falls. Others may attack one and that leads to one experiencing fear and the teams' level of respect also diminishes. In the groups I work with it is the nurses who establish relationships; they respect one another, they praise one another and pass on their various experiences. This because perhaps one nurse has children and a younger one does not, and in these aspects one discovers differences in experiences. Clinical assessments are made in those differences, not psychopathology.

11. Training objectives and methods

G.G.: *In this last part of our conversation I would like to ask you what the priorities are in today's training. Do you too see the need to associate training to a change in organizational models?*

P.F.G.: Without doubt.

G.G.: *How far can training work in ensuring the emergence of the need for change and its potential not only for those receiving it but also within the organization?*

P.F.G.: Training *per se* is not able to suggest the focal points of changing the organization. To achieve this, one could call in social-analysts, but the issue is that the sectors we are discussing have very high levels of stagnation. One can think of every possible conceivable organizational model (that is what they are called these days, once they were known as watchwords), but the real question is: what chance do they have of working as such, compared to how things actually work in practice? I can support a change in organizational models also in the form of a paper presented at a congress, but in real terms, which involves people, what ensures that things work is the informal organization of the decision-making processes. On this point one can have two perspectives; the first stating that it is better to ensure informal processes are transparent, thereby formalizing them; and secondly that the opposite is instead preferable. In this second case, the choice is not to keep the process completely secret, but to have the ability of a good clinical assessment in seizing the development of informal processes, without necessarily making them evident. If one makes them all public, one reduces the level of creativity. Informal processes must work at a preconscious level, and therefore must never be totally transparent, because when that occurs they are already falsified and other processes one is unaware of take place. At this point, training is no longer an abstract element, but becomes clinical capability. Who assumes this responsibility? So one has A who is capable of doing the job and B who can only provide you with chats about psychoanalysis.

G.G.: *Procedures are, however, preemptory. We are faced with systems defined through procedures, even if we are aware they are fictitious worlds. When one describes or passes on a procedure it is not to endorse it, but more often to test it and in some way ensure it fails from within. It has a fundamentally evocative power, putting into shape practices on the basis of certain criteria or parameters. So some procedures have to be taught, such as the fact that one has to visit some patients at their homes and that one has to follow the theorized and tested model as closely as*

⁹ L. Binswanger, Über Psychotherapie. *Der Nervenarzt*, 1935, 8: 113-121 and 180-189. Also in: *Ausgewählte Werke Vorträge und Aufsätze*, Band 3. Edited by Max Herzog. Heidelberg: Roland Asanger, 1947, pp. 205-230 (Italian translation: Sulla psicoterapia. In: *Per un'antropologia fenomenologica*. Edited by Ferruccio Giacanelli. Milan: Feltrinelli, 1970).

possible. Are there models for both services and procedures and what role do they have in the training process?

P.F.G.: Procedures are 20% of the decision making process; the point is how to not disrupt the other 80%. At that point one must develop clinical analysis regarding to what extent certain procedures become redundant and to what extent they are repetitive. It is at this point that intervention becomes identical to the analytical work. Defined in operational terms, clinical attention, as previously mentioned, implies making a prediction with very little information. It implies non-visible operations made by an individual. That is how a hypothesis is made and scientific verification takes place *a posteriori*, on the basis of probabilities. So, as far as procedures are concerned, constant attention is paid to all moments involving a lack of flexibility, which analytically one would describe as a “compulsive repetitive disorder”. These are the points one must visualize and try and unblock. If one thinks they can be unblocked with a service order then it is all over.

12. Training and leadership

G.G.: *At times service orders are necessary. We are aware that mental health presents situations that are potentially violent and potentially violate a person’s rights. The director of a Community Mental Health Centre (CMHC) is obliged at times to draft service orders...*

P.F.G. Yes, but these are statements or general principles, just like when one states that the private sector can be selective about admissions, but the public sector cannot. It is of course untrue. If one checks the real processes and verifies a few things, one realizes that the public service is selective, admitting some cases and excluding others. So there is a selection that everyone pretends does not exist. It is at this point that psychology’s instruments for learning intervene, and there is the emergence to the forefront of what to me seems inescapable; leadership capabilities by identification. In other words, one must set the example, and it is on the basis of this example that others organize themselves and plan. An example can be good or bad, and therefore choosing, effectively selecting a leader, becomes crucial.

G.G.: *Does a trainer, as the bearer of an identity and of identification processes, in turn develop leadership?*

P.F.G.: Just as an example, I have never played those group games in which one asks the group what they think. I start by saying what I think, and why I think it. Then someone else says something different and expresses his own opinion. The point is not whether I am right or he is, the point is that I think and he thinks, and so does another person. Everyone thinks and perhaps at the end you find yourself with ten different opinions, but each with an element of truth. This becomes the metaphor of the fly’s eye which sees 360 degrees, and if in a team there is someone who is right, then it means we have got it all wrong. At that point the issue becomes the responsibility assumed by the trainer, since he is also the organization’s mediator. He should not play the charisma card, nor use charismatic power regards to the conflict existing in the organization. On the contrary, one should pay great attention to this and succeed in cooperating both with the management and the base. Leadership is a factor that must activate both training and management. In our field it is measured on the basis of an ability to delegate, while always still continuously present and assessing delegations. If that is not done and one distances oneself, everything continues to progress and management is increasingly delegitimized. A manager may attend a conference and say anything he likes, but at an operational level no one listens to him anymore. Therefore this becomes the central issue for an organization. Service orders may be fine, but the management – those who are in charge – must be capable of correctly selecting directors with human resources playing the most important role.

G.G.: *With these questions I wanted to draw your attention to the ambiguities burdening training, the fact that it is increasingly tasked with resolving the organization’s conflicts and problems. Training is first of all addressed at people, asking them for change. It deals with organizational aspects and discusses them, detailing the contents that are then in some way presented and recorded...*

P.F.G.: At a declaratory level all that is fine, but what has actually happened and is still happening? This task is delegated to training, then training centers are asked to present a diagnosis of the organizational situation, they identify the problem and suggest a solution. When you train mental health professionals, the issue becomes the method one uses. For example, in psychiatric training one can only teach a classroom after having identified the problems and having knowledge of the subject one is addressing, and without that one would not be able to provide answers and would be restricted to providing information. Things are very different when the trainer has real experience in the field and therefore in-depth knowledge of an intervention sector with very specific characteristics and specifications. I do not wish to describe it as “unique”, but one in which there is a maximization of factors also present in other fields where, however, they are more circumventable. Immunologists, for example, like dermatologists, have realized that there are certain aspects of human resources that cannot be circumvented in terms of recovery, while, apparently, a surgeon can do without considering psychological aspects as factors affecting recovery. It is obvious that low-technology sectors are more sensitive to human resources, while those with an extremely high technological level are less so and the importance of this factor has only recently been discovered. Psychiatry must invest in human resources since that is all its work is based on.

Abstract. A conversation on psychiatric training: Giovanna Gallio interviews Pier Francesco Galli. This previously unpublished interview by Giovanna Gallio with Pier Francesco Galli was recorded in September 1999 as part of a research on “Goals, needs, and methods in mental health training” of the “Study and Research Centre for Mental Health” of the Italian *Friuli-Venezia Giulia* Region. This conversation, preceded by an introduction by Pier Francesco Galli, deals with the following topics: Effects of the transformation of the Community Mental Health Centers (CMHCs); Management of institutions operated under the principles of a private company (motivational systems and leadership); Management culture; Reproduction of human resources and of motivational potentials; Teaching or training? The psychiatry residency training schools; Psychologists’ training; Training and professionals paradigms; CMHCs as the setting for training; Conceptions of training (the supervision); Training and conflict; Goals and methods of training; Training and leadership. [KEY WORDS: psychiatric training, psychotherapy training, supervision, management in the national mental health system, leadership in psychiatry]

Riassunto. Conversazione-intervista di Giovanna Gallio con Pier Francesco Galli. Viene pubblicata una conversazione-intervista inedita fatta da Giovanna Gallio a Pier Francesco Galli nel settembre 1999 nel quadro della ricerca sul tema “Obiettivi, bisogni e metodi della formazione in salute mentale” per il *Centro Studi e Ricerche per la Salute Mentale* della Regione Friuli-Venezia Giulia. Questa conversazione, preceduta da una nota introduttiva di Pier Francesco Galli, tocca, tra gli altri, i seguenti temi: Effetti dell’aziendalizzazione: sistemi motivazionali e *leadership*; La cultura del *management* organizzativo; La riproduzione delle risorse umane e del potenziale motivazionale; Insegnare o formare? Le scuole di specialità in psichiatria; La formazione degli psicologi; Formazione e paradigmi professionali; Dove fare la formazione: i Dipartimenti di Salute Mentale (DSM); Concezioni della formazione: la supervisione; Formazione e conflitto; Obiettivi e metodi della formazione; Formazione e *leadership*. [PAROLE CHIAVE: formazione in psichiatria, formazione in psicoterapia, supervisione, management nella sanità, leadership in psichiatria]