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# **Extreme Trauma in a Polluted Area: Bonds and Relational Transformations in an Italian Community**

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## **Abstract**

In the community of Casale Monferrato, exposure to asbestos has been an extremely traumatic event that has caused cancer and death and that has affected a variety of social and environmental aspects of the people and community. When an entire community is severely traumatized, psychoanalytic group therapy seems to be the most suitable therapeutic setting: It allows for the historization of the event and the creation of multiple narratives of somatopsychic suffering, producing a transformative effect on non-mentalized emotional aggregates. Making reference to clinical material, I will show how the possibility of sharing, with other minds, the meaning of the trauma has also brought into the field the vital aspects of each participant, which are possibly not very intense in each individual, but consistently present in the functioning of the mind of the group. I will also illustrate how this led to the development of a new and more mature psychic asset, where painful and deadly experiences connected to the trauma could be faced.

**Keywords:** Massive Trauma, Contaminated Site, Group, Mourning, Transformation

## **A psychoanalytic overview of collective trauma in polluted areas**

In recent times, psychoanalysis has placed an increasing focus on large-scale disasters, that is, natural catastrophes, accidents, torture, war, and terrorism, and their devastating impact on the body, the mind, and relational bonds has been taken into account (Boulanger et al., 2013; de Dunayevich & Puget, 1989; Rosenbaum & Varvin, 2007; Varvin, 1995, 2003, 2005; Volkan, 2001; Wusmer, 2004). Such traumatic events can be considered as real social catastrophes, overwhelming and unbearably painful experiences, which leave longlasting marks on both individual and collective identities.

In this paper, I will focus on a particular type of collective man-made trauma that has only recently been taken into account: living in a polluted area where the major economic source intentionally caused

illness and death among the citizens in the name of a profit-driven logic. Taking into account such a multifaceted traumatic reality entails reflecting on its effects at an individual, communitarian, and cultural level (Rosenbaum & Varvin, 2007), and therefore, also bearing in mind its fundamental role in the construction of identity.

According to Bohleber (2010), the formation of identity can be understood as a dynamic process, resulting from the comparison and balancing among one's inner, unconscious fantasies, representations of oneself and of others, social roles, expectations and behaviors, and the real external world. This “*endless*” balancing process gives rise to the feeling of identity. Therefore, identity shapes one's subsequent relationships with oneself and with others.

In my clinical experience in polluted areas (Borgogno F. V., Franzoi, Barbasio, Guglielmucci, & Granieri, 2015; Granieri, 2008a, 2013, *In press*; Granieri & Borgogno F. V., 2014; Granieri et al., 2013; Guglielmucci, Franzoi, Barbasio, Borgogno F. V., & Granieri, 2014; Guglielmucci, Franzoi, Zuffranieri, & Granieri, 2015), I have observed that geographical proximity to a permanent environmental disaster due to the emission of asbestos results in a traumatic situation experienced by the entire local community, often leading to cancer and death. This is the case of Casale Monferrato, a city in northwestern Italy, in which exposure to asbestos has resulted in the local Health Services reaching an impasse because of the exponential increase in healthcare demand.

Over the years, the extraction and processing of asbestos have resulted in the illness and death of thousands of victims, affecting not only the workers of the factory but all the citizens residing in the Health District of Casale Monferrato (Bourdes, Boffetta, & Pisani, 2000; Fazzo et al., 2012, 2014; Goldberg & Luce, 2009), who, even today, continue to be at risk. Indeed, the inhalation of asbestos fibres has led to the outbreak of a rare and fatal lung cancer, malignant pleural mesothelioma<sup>1</sup>.

Taking into account Freud's arguments in *Civilization and its Discontents* (1930), for almost eighty years, the factory has guaranteed the citizens employment, economic prosperity, and security. In the “golden-age” of Casale Monferrato, the vast majority of families used to have at least one member working

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<sup>1</sup> This is a rare neoplasia that affects the thin tissue that covers the lungs and the thoracic cavity, and involves an uncontrolled growth of cells. The first symptoms of pleural mesothelioma may be pain in the lower back or in one side of the chest, shortness of breath, cough, temperature, fatigue, weight loss, difficulties in swallowing, or muscular weakness. The prognosis is extremely poor. The average life expectancy after diagnosis is about nine months. Only ten patients out of hundred are still alive five years after the onset of the symptoms, and this number keeps decreasing over time. Moreover, pleural mesothelioma has an incubation period of about thirty years: In the next twenty years, five hundred more deaths are attended and the number of deaths is expected to peak between 2015 and 2020 (Fazzo et al., 2012; Ferrante et al., 2007; Furlan & Montarino, 2012; Lo Iacono et al., 2015; Magnani et al., 2008; Marinaccio et al., 2007).

in the factory, as a result of which an invisible tie of belonging was created between the factory and local community. The identity of the citizens was progressively shaped around the idealization of a powerful mother/factory that fed her children with food that seemed tasty, but that turned out to be toxic. The presence of the factory entailed making the community pay a very high psychological price: To some extent, this price was the limitation of freedom, possibilities, and life itself (Guglielmucci, Franzoi, Barbasio, Borgogno F. V., & Granieri, 2014). In such a context, the factory becomes a sort of external, obscure force, powerfully organizing implicit and explicit demands of relatedness and collusion on the basis of the explanation offered by the owners: The ego was forced to bear the threat concerning the danger of an unconscious collusion with the factory, refusing to recognize unwise decisions and irresponsible behaviors for what they were and consequently accepting living in an extremely dangerous and toxic environment presenting high risks for the residents' lives and for the lives of the residents' loved ones.

This dynamic may exacerbate the way in which victims experience a situation that is already traumatic in itself. In such conditions, people start perceiving the external world as unsafe and chaotic: This becomes incomprehensible and ungraspable, betraying and violating the person in terms of his or her most intimate aspects. Therefore, it is easy to observe the emergence of unconscious conflicts between life and death and economic prosperity and mourning. Living with the fear of an “aerial contagion” by an “invisible killer” paves the way for feelings of helplessness and hopelessness and for shared aggressive fantasies directed toward the source of the trauma—the factory itself. People who have undergone such a cumulative trauma show personality dysfunctions, anxiety, and depressive states, an increased amount of dissociative experiences, somatizations, and enactments entailing many somatopsychic features (Granieri, 2008a, 2013; Granieri et al., 2013). Facing the trauma, the victims use defense mechanisms aimed at maintaining, protecting, modifying, or repairing the shared group identity (Volkan, 2002). Denial, splitting, repression, and reduced emotional expression (Cotrufo & Galiani, 2014) allow the individuals to contain their overwhelming anxiety and the profound feelings of shame and guilt due to the fact that they have accepted something dangerous for themselves and their families. In Casale Monferrato, I met many citizens that defined themselves only through their losses and their bond to the factory.

On the one hand, adopting a defensive mimetic attitude has allowed some of the citizens to tolerate a reality that would otherwise have been experienced as too threatening and unbearable. This strategy can be understood as a kind of social adaptation to what the owners of the factory told the community. On the other hand, however, some other citizens achieved a sense of defensive cohesiveness by initiating and

fighting a legal battle against the factory<sup>2</sup>: The factory became a common enemy to fight against for these citizens, who took up the role of paladins of a right cause. In this respect, it was necessary for the inhabitants of Casale Monferrato to find a balance between *immunitas* (in the sense of a self-protective isolation and closure within one's own identitary boundaries to protect themselves from the contagion that derives from the Others), and *communitas*, which indicates the opening of each life toward another and the resultant possibility of facing the fear of contagion in the encounter with the Other's specificity (Ambrosiano & Gaburri, 2013). This balance was extremely difficult to achieve, as the people of Casale Monferrato, who individuated themselves in the group, felt that they could return to be alive and unique, but in doing so, they had to face the destiny of a sort of fated community (Granieri & Borgogno F. V., 2014). Security and protection can only be obtained through a fusional coupling with the Other: an *ingroup* kind of narcissistic identification (Freud, 1921) that creates a symbolic universe within which there is no space for anything different or alien (Bohleber, 2010), and a *mass identification* (Gaburri & Ambrosiano, 2003) in which everyone is a victim of the factory, everyone has lost somebody, and everyone is destined to die because of asbestos pollution.

### **What type of psychoanalysis is helpful for members of a polluted community?**

The repeated healthcare demands made by the citizens first led the Health Services and then the Piedmont Regional Government to contact the Post-Graduate School of Specialization in Clinical Psychology, (of which I am Director). They asked me to devise a psychotherapeutic intervention for the community. This request and my own geographical proximity to Casale Monferrato prompted me to ask myself the following questions: How could psychoanalysis possibly contribute to such a situation? How could psychoanalysis help a community unable to mentalize and symbolize affective experiences by the devising of therapeutic protocols tailored to actual needs (rather than to reiterated requests) of the community?

There is strong evidence that psychoanalytic treatments are particularly helpful for many traumatized patients, helping them survive extreme experiences and complicated losses (Varvin, 2015). Moreover, when the trauma involves the entire community, it is essential to explore group mental life and recognize the importance of the *real* environment (Borgogno F., 2007, 2011) in which citizens have lived

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<sup>2</sup> The appeal sentence condemned the accused to eighteen years of imprisonment, on grounds of causing a voluntary permanent environmental disaster and of voluntary negligence in health and safety measures. The court also decided that the region of Piedmont was due to pay a fine of 20 million Euros; the Casale Monferrato City Council, a fine of 30.9 million Euros. Last year, the Court of Cassation overturned this sentence, declaring that the statute of limitations was expired and the crime was not prosecutable.

and continue to live, promoting the restoration of the Ego on both an individual-intrapsychic and a social-interpersonal-transpersonal front. This is why I believe that a psychoanalytic group (Bion, 1961) is a suitable community-based trauma intervention and why I also think that it provides the most suitable setting to work through the inhabitants' pain, allowing for the historization of the illness and the creation of multiple somatopsychic narratives. A cancer diagnosis in Casale gave rise to intense feelings of guilt and shame. While working with these patients, it is fundamental to bear in mind each one's unconscious representations about why they have become ill, why they have decided to continue living in Casale Monferrato (notwithstanding the risk to their health), the economic interests connected to their work at the factory, their collusion with the owners of the factory, and so on. These unconscious representations have to be worked through in the psychoanalytic sessions. However, it is fundamental to bear in mind that in the case of a contaminated site, real-life events have a continuous impact because every day, there can be a new diagnosis or a new death.

From among the various types of psychoanalytic groups, I chose the multifamily group (García Badaracco, 1989, 2000), a type of psychoanalytic setting developed for psychiatric patients. It is an “open doors” group, whose participants meet once every week. Each session lasts for ninety minutes and attendance is open to patients, their relatives, health workers, and whoever else wishes to participate, offering the possibility to simultaneously work on the individual, familial, and social dimensions of the mind (Borgogno F. V., 2010). As García Badaracco highlights (1989, 2000), the functioning of the multifamily group may be understood as an “*extended mind*,” whereby each participant enriches the whole by contributing his or her point of view: Indeed, each individual contribution stimulates the potential of the group to generate associations through a continuous interplay of identifications, fostered by the fact that participants who are not directly involved in a situation regarding other people or other families can think more clearly. The mental process promoted by this mirroring in the other members also promotes the acquisition of greater courage to spontaneously express oneself in front of other people, who increasingly appear as presences capable of containing and favoring the development of genuine ego resources. In such a situation, both transference and countertransference are multiple and are dispersed on therapists and other members of the group.

As the victims' psyches are facing the destructive impact of a social catastrophe, it is necessary to turn to flexibility and elasticity in clinical practice (Ferenczi, 1928), as well as to be able to move back and forth from the couch. Therefore, I have decided to transpose the multifamily group to a clinical context that is different from the original one—but which is, at the same time, similar into several aspects. Psychiatric patients who are unable to separate themselves from their families are profoundly dissimilar

from patients who are forced to separate from their loved ones in a very short span of time, as is the case with patients with pleural mesothelioma. Moreover, in Casale, death was often the main theme of the group, revealing deep, deadly anxieties in both patients and their families, as a consequence of living in a “*murdered/murdering environment*.” However, in both circumstances, it is not just necessary to work with the individual patient but it is also necessary to work with the families and the health workers. Moreover, it is necessary to simultaneously bear in mind the individual, familial, and community dimensions. Furthermore, in the families of psychiatric patients, there is an “identified patient” who shows the symptoms, but the psychological suffering circulates in the whole family, and when the identified patient starts to recover, the other family members can start expressing their psychic pain. Similarly, in contaminated environments, there are mesothelioma patients and people who die because of the illness; however, the illness can strike at any moment and at a family member of any of the inhabitants. Finally, the multifamily group is a particularly suitable tool for patients affected by pleural mesothelioma, who may choose whether or not to participate in the group and for how long they wish to participate, depending on their physical conditions at a given moment.

My clinical journey involving working with people living in polluted environments started in 2006 with an investigation of the psychological effects that asbestos had had over time on the local community. In April 2010, the first multifamily group for the population of Casale Monferrato was started. I conducted the group with Francesca Viola Borgogno, an International Psychoanalytical Association (IPA) candidate. In accordance with the original setting, the group met once a week and was open to whoever wished to participate: patients, relatives, health and social practitioners, and, in general, all interested citizens. Each session lasted ninety minutes and was followed by thirty minutes of reflections, which was carried out by us therapists alone, wherein we tried to elaborate on and analyze what had transpired in the group<sup>3</sup>. Indeed, these “moments of thinking” were very important for us to observe changes that had occurred during the sessions and to start thinking together about what had changed (or not) and in what specific circumstances and for what reasons.

Over the years, almost fifty people have participated in the group, most of them being caregivers, who, in the course of their own lives, had been helpless witnesses of the complicated loss of several of their family members. This group of relatives seemed to have remained completely alone after their losses: Many had lost the ability to be moved by their feelings and to connect their experiences to feelings such as joy and pain. They had lost, due to the freezing of their feelings, something profoundly intimate and

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<sup>3</sup> All the sessions were audio-recorded and transcribed verbatim, and informed written consent was collected from all the group participants.

personal, and at the same time, a bond with the world of mourning was created. These little parts that are still alive “*will be just strong enough to sustain a life of routine*” (Ferenczi, 1932, p. 32).

Although the health professionals openly declared an interest in the multifamily group, they participated only sporadically, often justifying absences with “hospital emergencies.” This behavior seems to highlight the difficulty that these professionals face in separating themselves from their habitual role of taking care of only the physical aspects of the illness: Indeed, they tried to avoid confronting the suffering that circulated in the group. The lack of health professionals’ participation generated in the group, fantasies connected to group members’ feelings that psychological work was considered as “*not important*” by the health professionals: These fantasies have been extensively explored in the group (Guglielmucci, Franzoi, Barbasio, Borgogno F. V., & Granieri, 2014).

At the same time, even though our group was an “open door” group for asbestos victims and their families, we were very surprised that no families participated in the group; however, we could only accept those who turned up for the sessions. For a long time, during what I called our “moments of thinking,” we asked ourselves what the possible reasons for this absence of victims’ family members might be, but then we realized that there indeed were families in the group, but they were families of the dead. For every person who turned up, several others were evoked: In the majority of cases, families were present as ghosts, who spoke through the memories of the group members who were still alive. Moreover, in such a circumstance, where everyone is involved in the risk of contagion and anyone can get ill at any time, there is often no scope for the citizens to talk to each other about what is happening. Session after session, participating in the group, listening to more and more traumatic memories, and becoming aware that all the participants had had very similar experiences made the participants more comfortable with thinking, sharing, and talking about these unacceptable thoughts, feelings, and experiences.

A few patients with mesothelioma and asbestosis also participated in the group, though somewhat irregularly, because of their medical conditions. Working with patients with such a short life expectancy raised intense countertransference feelings of helplessness in the co-therapist. Sometimes, I felt that my work was threatened by the feeling of impending death that constantly lingered in the group and this feeling could be traced in the narratives of the sessions. As I emphasized above, in the group, transference and countertransference were directed toward multiple objects and then “diluted,” thereby offering the possibility of making feelings more bearable and expressible in different words by different participants, thus representing an extremely significant therapeutic factor. The group worked as a sort of marginal land, with regard to the functioning of the mind, between primary and secondary processes. It constituted a sort of third analytic space where enactments and projections took place. The encounters with the co-therapists



and with the other members of the group contributed to shaping this thirdness as well as subjective and intersubjective movements, creating an intermediate space in which to reflect upon similarities and differences in traumatic experiences (Aron, 2006; Green, 2004; Ogden, 1994). In other words, in this intersubjective field, transference and countertransference were “communicative outposts” of thoughts still in search of a thinker—thoughts that were had in different situations by a co-therapist, a patient, or a family member of a patient, who would then transform them (Bion, 1965). Hence, a “cooling down” took place, as if handling something incandescent had become possible because the presence of many people functioned as the weft of fireproof gloves, which made painful experiences and thoughts touchable and instantly less traumatizing (Granieri & Borgogno F. V., 2014).

Lorenza: Ever since mother died, I haven't been able to sleep in my house, so I sleep at my boyfriend's place instead. That way, at least I can have a few hours of sleep; what can I do...

Lia: Yes indeed, being alone... Don't even mention that! Before my husband died, in fact, very shortly before he passed away, my doctor said to me, 'Don't stay on your own anymore.' It was as if he meant, 'Brace yourself. And prepare your daughters too.' Yup, how awful...

Everyone remained silent for a while.

Lia: Anyway, I work at the hospice. Yes, I offer support to those who don't have much time left. And do you know what the most terrible thing is? A mother's suffering, the pain of losing a son... It's as if someone is ripping your skin off.

This theme was addressed time and again in the following sessions, during which some of the participants put into words transference sequences including important losses such as a son's death, and at the same time, also provided the group with “ideation sketches,” which were useful to start thinking together about the experience of the death of one's loved ones.

Lia: I lost a son in a car accident when he was 27. He walked out of the house one day and I never saw him again. They just killed him. He was in the back seat of someone else's car. And for six months, I myself couldn't tell if I was dead or alive. [...] After that, it was my husband's turn, and then in four years' time, three out of four people who were alive in my family [...] got cancer.

The group grasps the life-oriented aspect of Lia's story when she talked about her voluntary work at the hospice with the Associazione Volontaria Ospedaliera.

Lia: You deal with ill people who are alone. [...] You go to the ward they assign you to and stay there for two hours [...]. At first, I was in the ward with male cancer patients, so you can imagine! Now, I work with boys with multiple and lateral sclerosis [...] I started after my son's death.

We worked together on the pain involved in thinking about the situation in Casale, about the dead workers—old as well as young ones—and on the fact that facing death by mesothelioma triggered thoughts on existence as well as on the life and death of each and every group member and of their children.

A.G.: One struggles to start thinking [...] it is easier to say that joining forces and helping each other out is sufficient, assuming that all groups are the same....

Free associations on the subject of children who died kept emerging in the following sessions, until the theme became intertwined with that of children who survived.

AG: A lot has been said on children you have lost—some in an accident, some to mesothelioma—but only occasionally have you talked about their siblings, who have seen you suffer so much.... And it took you some time to even mention them.

[...]

Ida: But they did not allow me to—my son didn't, and my grandson didn't either. I would never stop speaking about my daughter [*who died of mesothelioma*] but they didn't allow me to .... And I respected that.

As the sessions continued, a particularly painful moment arose when the Institution questioned whether the clinical work could be continued as a result of the spending review. The group thought of the possible reasons as to why it had become so difficult to continue working together with the Institution, which had initially been very favorable with regard to the implementation of the initiative. Of course, a number of external reality events may have contributed to the emergence of internal turbulence both among the members and among the co-therapists of the group: These include changes in the Council administration, the end of a number of fixed-term contracts, the difficult commute from Turin to Casale Monferrato, and the associated fantasy in the group about a decrease in motivation on the part of the therapists.

In a reproachful tone, Lia commented on our being slightly late due to weather conditions, stating, "*I feared you would not come. Perhaps they are afraid of the fog, of the snow, and now also of the rain.*"

Exchanges then followed on the distance between Turin and Casale Monferrato and on the presence (or absence) of group members and therapists, which, in countertransference, generated feelings of being blamed.

F.V.B.: I am thinking about how interesting this is: On the one hand, I feel that if someone does not show up, people are sorry about that, but then those who do actually show up also get the share of beatings of those who have failed to show up.

Lia: We are not criticizing you [...] Come on!

[...]

F.V.B.: So, since today, we are talking about my feelings, I am happy to see Ida.

Ida: What?

F.V.B.: Today, I am happy—since I am talking about my feelings, let's switch roles! I meant to say that I am happy to see you.

Ida: Thanks, I am pleased because tonight, I feel much better than I did on Thursday, no doubt.

Since one of the co-therapists managed to refrain from denying the real suffering associated with the uncertain future of the group, it became possible to work on feelings that were occasionally rather strong and present in the group as bastions (Ferro, 1993). This gave rise to a process of transformation, which allowed the participants to increasingly approach opposing feelings such as rage (for possibly not being able to see the deceased again) and pleasure (arising from the knowledge that they will survive and be well), the entire process leading to a more stable integration.

It was important to combine the different feelings and experiences of the group participants, with the external reality issues revolving around the actual opportunity to continue with the group.

AG: When we started working together, we had the authorization to do so for two years [...] now, starting to work at a deep level also means having the time to work with what emerges in the process. [...] I believe that this group and the combined psychological work carried out at the hospital have both been great opportunities. It is highly possible that we could have made even better use of them, but this is how things went, as we are now in the position to say [...] I also think that this experience has taught us all that if one wants to do this kind of work in Casale, it is actually possible only if one believes in it, because it takes time before one finds people who are willing to share their experiences.... Thirty years in this case. [...] Talking about money is sad, but it is also sad when the topic of what work has been done arises and what has been accomplished is not acknowledged: The two are very

different kinds of pain, but they are both unpleasant. There are many levels at which when things are done, they might not be acknowledged, and every time this happens, it is sad.

[...]

Ida: I'll only say one more thing and it is going to make you laugh. I arrived home at seven and my feet were feeling really hot in my shoes, so I put them in cold water.... with my tights on! [...] So, I came here with wet feet and I feel better than before...

The work within the group allowed the emotions related to illness and death to regain some life. It was now possible to recognize and put into words unconscious and embodied feelings, non-mentalized aggregates that had to be thought in order to promote an authentic transformative process (Granieri, 2011a,b). I will now focus on some clinical work with Giulia, a group member whose experience and transformation in the group, in my opinion, illustrates this process and nicely describes my clinical approach to the group.

### **Clinical case**

Giulia was a forty-year-old patient suffering from pleural mesothelioma. She was still alive five years after her diagnosis. The transformation related to the work in the group allowed her to tell her sons about her illness and enabled her to share her feelings with her husband.

Giulia: I've been ill for five years. When I was first diagnosed, I was told that I had just four to five months left. I used to work, so that I could look after my children and the house. But I had to leave my job to get treatment: I was forced to stay at home. I used to take pills for the chemotherapy, then injections for two consecutive weeks, and then it became every alternative week, and so on. I've always borne it rather well. [...] I never told my children that I had mesothelioma. My husband doesn't want to tell the children, and I cannot make up my mind if I should. Quite simply, I just cannot talk about it. My mother is eighty-one, she doesn't even have a clue, and I just want her to go on with her life. She is already a widow: In just three months, the same disease took her husband away from her. My husband does not want to hear about it. I cannot have this conversation with him. I would like to tell him what I wish for him and for my children if, one day, I am no longer with them. But no, I am not allowed to. My husband won't hear of it.

Rachele: I think they already know...

Giulia: I've never told my children. One was six years old; the other, twelve. I couldn't bear telling them I had just five months to live. But now, I haven't undergone any treatment for sixteen months.

F.V.B.: What do you feel?

Giulia: I, myself, am prepared to tell them: After all, one of my children is seventeen; the other, twelve. One day, the older one and I came across a street advert with a message on mesothelioma. He asked me, 'Why are you looking at that? That disease is fatal.' I explained to him that this was not necessarily true, that treatments are available, and that in any case, one should be aware of such things. One morning, when I was lying on the couch after chemotherapy, he approached me and asked, 'Mom, are you having chemo?' I replied, saying, 'Even if I am, it is just a cure for infection, like many other diseases.' He looked at me and said, 'But you did not lose your hair.' Indeed, when I was having chemo, I never became bald—I lost some hair, but that was it. Instead, my son had seen another person who had lost all her hair because of chemo.

A long pause marked the border between Giulia's possibility of communicating with her closest relations and her way of being in the world, in her social group, as a person who is aware of her illness.

Giulia: My husband insists that I refrain from talking about my illness. I, on the contrary, have learned to talk about it with pretty much everyone—I felt the urge to do so. I made myself available to provide guidance and information on how I am being treated to anyone who might ask me about it. I tell people which doctors I got in touch with, which hospitals I went to, and I describe the entire process I went through. My home became, and still is, some kind of a call center—people call and I provide all the information.

The group participants observed that perhaps the people who are closest to the patient struggled to offer sustained support because they themselves were suffering. Through the group work, it became more tolerable to understand the differences in character between Giulia and her husband Giorgio. Further, the essence of what the people of Casale tell each other as members of a community emerged, besides the nature of the exclusive patient/caregiver relationship.

Rachele: But Giorgio suffers a lot...

Lorella: Yes! When we meet, he always tells me 'Thank you. Thank you for what we are able to give you and for what we are doing together.'

Giulia: Giorgio can be harsh, but he is a very good man...

Rachele: Women tend to express their feelings more. But he talks to me...

[...]

Giulia: I tried to tell him what I would want for my children. I'm not saying that I am going to die tomorrow; I just want to express my wishes about my children, so that they can keep on studying and move on in peace with

their lives. And I want him—he is four years younger than me—to be able to make a new life for himself. But he doesn't even let me start talking. He immediately becomes hostile.

Giulia's account became charged with emotion when she told the group about the deep pain she felt when she realized that her husband had completely failed to consider one of her wishes.

Giulia: [I wanted] to build a wall around the house and the garden, and a little path in the garden with pebbles and flowers with different colors on each side. I would have enjoyed choosing flowers and colors together with Giorgio and talking to him about how that would change the appearance of the house. But none of this ever happened. My husband built a solid, functional gate in just a couple of days.

At this point in the session, it was important to gather, based on what one of the therapists said, the different types of thoughts that emerged in the group.

A.G.: It is important to communicate with people and experiment with trust to find out whether there is a space in others, wherein what we say can be harbored and thought about. When this trust falters, or we feel the absence of such a space, perhaps talking appears useless. This perspective can change, though, if we predispose ourselves to build, together with our audience, a communal space, beginning by sharing how important its very existence is for us. Of course, this takes longer, and more energy is required when one is ill, because at times, a sick person may feel completely deprived of energy. However, it is also very mortifying to find ourselves completely alone afterwards, when we go through a period of improved health.

The only male member of the group, Vincenzo, came forward to speak. He is a handsome man in his early seventies, suffering from a serious pulmonary condition caused by asbestosis. He is not always well tolerated in the group because he has a low voice due to his illness, and because of the apparent nonchalance with which he addresses the group, which in turn suggests that he feels as though the group cannot hear his words. He is firm when he expresses his thoughts, which are shared in an "impressionistic" way, in a low voice, in a clear-cut and direct manner.

Vincenzo: My daughter is a masseuse. [His voice is low as usual and it is difficult to understand him, not just because of his volume but also because he mumbles]. My wife suffers from cervical pain, and is always complaining: I'm in pain, I'm in pain, I'm in pain. And I say to her, 'Whenever you are in pain, you must express what is essential and should also describe the pain and say where it hurts. This may result in your daughter helping you.'

A.G.: Vincenzo here evokes a beautiful image about ‘expressing the essential.’ But for each of us, the ‘essential’ is something different.

Toward the end of the session, Laura came forward to speak. She is a journalist who works for a newspaper based in Alessandria, Piedmont. She was attending some press conferences in Casale when she decided to take part in the group.

Laura: I feel extremely embarrassed in front of these tragedies. I haven’t experienced anything like this yet, but I live in fear of becoming ill, and I’m even more scared that my daughter will get ill. My daughter and I now live in Alessandria, but in the past, we lived in Casale for several years, and I know many people who have become ill, and died, without having had any contact with the factory.

Giulia: Fear is an ugly thing; yet, it is nevertheless something that makes us alert about the future. Certainly, fear is a painful feeling, but it makes you think and talk about those who are suffering more than you. In the end, you realize how lucky you are. Fear fills you with anguish, it makes you sick, and it’s an obstacle in your life. I, on the other hand, think that it is important to believe in something and then, if we become ill, we’ll embark on the journey of the cures. It is basically pointless to torture oneself with these useless questions one is often asked during interviews, like ‘What do you think about the fact it was *you* who became ill?’ Once, I asked my oncologist, ‘Do I have any chances of living?’ His words were important to me; his answer, unforgettable. He said, ‘Your willpower and your spirit can move a mountain. Thirty percent of whether you will recover depends on the medicines; the other seventy percent, on the patient.’ Sure, after the diagnosis, I experienced deep terror: fear of physical pain, fear of not being able to look my children in the eye, fear of being looked at by my fellow townspeople as yet another ‘loser’ of the group. I spent the first twenty days locked in the house for fear of being asked questions: I rested and I prayed. But then, I thought that I couldn’t lock myself in the house for fear of being looked at or stared at by other people. So, on a Saturday, I dressed up and went to mass. I felt like the odd one out; everybody was looking at me: I was already dead to them. I started to talk about it, and something changed in me. Before, I’d had the tendency to withdraw into myself, but at that moment, I said ‘No, I refuse to!’

A.G.: Laura’s candor in talking to us about her fear, and the fact that she is a citizen of Casale, has prompted, in the group, the fostering of life experiences that are characteristic of the *Casalesi*: They look at each other, scrutinize each other, and they listen for coughing while walking down the streets or to the church. They almost think that an invisible plague could hit them at any moment and are constantly asking themselves who the next victim is going to be. But maybe something will change when they find a vital aspect inside themselves, connected with their will to live.

Giulia: That’s what happened to me. As I was walking down the nave of the church with all those gazes on me, I found myself thinking, ‘I want to live, I don’t want to die,’ for myself, for my children. I’ve got spirit—as they used to say, I’m a Duracell.

## Final Considerations

The people participating in the group asked to be “understood in having value and existing for another person who affectively and mentally participates in their particular experiences” (Borgogno F., 2013, p. 28). Getting close to the participants’ most profound feelings and sharing our desire to work together is what entailed cultivating the possibility of “*feeling with*” (Ferenczi, 1932). It was possible to work not only with the people who were physically present but also with the ghosts of the dead, who were alive in the participants’ minds. During the sessions, it gradually became possible to create a field in which to think about, experience, and digest traumatic emotions (Granieri & Schimmenti, 2014), and where it was also possible to integrate dissociated parts of the Self (Schimmenti & Caretti, 2014). The participants also needed the co-conductors to have a “*perspectival vision*” (Borgogno F., 2014a), that is, to trace and bring to light, lively and vital aspects in a population immersed in death and to support their potential for growth, transmitting to them, the hope that it is possible to psychologically survive the trauma. Thanks to this work, the group could authentically take an interest in understanding what it means to live in Casale and become ill. A moment of difficulty for Giulia—the need to resume her chemotherapy—represented an opportunity to get in touch again with the quality of her emotional experiences and to share them, paving the way for a new possibility of action in the world. Giulia eventually told her sons about her illness. In this sense, the analytic word has become embodied, and has become not a substitute but a prelude to action. In Bion’s words: “*I will hypothesize that the key point for a mind phenomenon – be it a thought, an idea or a hypothesis – to become action [and a possibility of an authentic experience in life] in the course of psychoanalysis is the time of public-action*” (Bion, 1992, p. 203). This refers to “making something public,” an operation that often stimulates recovered creative bodily potentials. Through “public-action,” the language have become a language of emotions (Gaburri & Granieri, 2008; Granieri, 2008b; Seganti, Albasi, & Granieri, 2003), reconstructing the sense of belonging and the possibility of sharing common sense compromised by trauma (Bion, 1992). In these traumatic circumstances, an “*act of credit*” (Borgogno F., 2014b) is indispensable: it has to be directed to the patients and caregivers’ potential, establishing a space between the past and present, in order to regain personal history and the capability to live a present and a future less tainted by the trauma.

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