



Development of a Brief Psychoanalytic Group therapy (BPG) and its application in an asbestos national priority contaminated site

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Abstract

The aim of the present paper is to describe the development of a Brief Psychoanalytic Group therapy for contaminated sites and its application in the National Priority Contaminated Site of Casale Monferrato. Before presenting the core of the clinical intervention, a brief examination of some clinical features encountered working with malignant mesothelioma patients and their caregivers is offered. These aspects have been pivotal elements in the construction of a psychoanalytically oriented time-limited (i.e., 12 sessions) group therapy. This model of intervention was designed by one of the Authors (AG) and is aimed at reducing the impact of living in a threatening place where both physical well-being and health are put to the test. At a psychological level, in fact, living in contaminated sites arouses death anxieties, which can deeply compromise the quality of time remaining to live together with loved ones after a fatal cancer diagnosis.

Key words

- cancer
- malignant mesothelioma
- caregivers
- psycho-oncology
- brief therapy
- group therapy

A THREATENING HOME

There are places worldwide where a large portion of the inhabitants are getting ill and dying because of the severity of pollution produced by hazardous industrial facilities. These places have been called contaminated sites (CSs), and they are a big concern for public health officials and clinicians [1]. They have also revealed the presence of cultural policies and economic ideologies that put the health of human beings in the background [2, 3]. The impacts of pollution and contamination are many-faceted and complicated, and can be fully understood only by taking into account the deep relationship occurring between the external world and one's personal identity.

The country where everyone lives, the place where he/she was born or where he/she spends most of the time with family and friends, as well as one's own professions and workplaces, are key elements in the construction of identity. It can be said that the cultural and social milieu in which everyone was born, grew up, and lives shapes his/her mind and the way he/she relates to the others [4].

In 2006, one of the Authors (AG) was called to understand the psychological characteristics of an Italian community living in the National Priority Contaminated Site (NPCS) of Casale Monferrato and to investigate its specific suffering. Since the processing and

treatment of asbestos has become the major economic source in Casale Monferrato, citizens were confronted with the multifaceted situation they were obliged to live in: on one hand, the majority of them were employed by the Eternit factory, one of the largest companies in Europe for asbestos processing; on the other hand, they became overwhelmed by a tsunami wave of deaths due to the unfair and tragic diagnosis of malignant mesothelioma (MM). Because working in the Eternit factory for decades has been a defining aspect of both personal and community identity, for those still living in this area it was very hard to accept that the safe place in which they have lived stopped being safe and that a large number of people were dying because of a fatal disease connected to asbestos inhalation [5-7]. Thus, the representation of the factory as a safe and fulfilling workplace little by little gave way in their minds to a fearful image of death, which gave rise to unsymbolized and fragmented affective scenarios related to these traumatizing experiences [3, 8]

Starting in the eighties, ubiquitous anxieties became more and more frequent all over the town, and each suspicious radiography or persistent cough was interpreted as an alarming symptom of MM, evoking an intense fear of death in the entire population [9]. These traumatic experiences are indelible marks inscribed in



the citizens' minds but are dissociated and excluded in their narratives because of their disorganizing impact. Under these circumstances, ambivalence and internal conflicts (also related to a common sense of loyalty toward a company that pays the wages) put the individual stability of the citizens to the test as they were threatened by the loss of a fundamental source of security. The profound loss of the sense of security "in their own homes," together with the intensity of their mourning, gave rise to intense anxieties and fears with potentially destructive consequences for personal identity [10-12].

From a psychoanalytic point of view, living in an NPCS not only implies a continuing circle of illness and death but also undermines the psychic balance of individuals and groups because of deficiencies in the representational system related to such traumatic experiences of loss. Common responses to traumatization – depending on the mind's level of integration and quality of functioning – could range from a frozen affective internal state built up from dissociation and denial to resilient behaviors developed after being exposed to traumatizing events [13]. On a clinical level, however, it is important to remember that a resilient response to trauma does not necessarily imply the elaboration of the trauma itself [14]. For example, in response to the fatal prognosis of MM, the helplessness experienced when a close family member is dying and we are not able to help or save him/her, or the unconscious feelings of guilt because we are surviving, people could organize group actions to demand compensation for the damage they have suffered, for what was taken from them. These actions are certainly the expression of a strong will and of a solid and cohesive enough psychic structure, but they do not constitute the ability to reflect upon what is happening and what happened in their own lives, to organize traumatic experiences in meaningful scenarios, to freely express painful thoughts and feelings in their narratives, or to engage in mutual and reciprocal relationships. One of the major risks we can encounter under these circumstances is the building of a "new" negative identity, through which people define themselves in relation to illness, void, and loss. Indeed, it could be easier for them to define themselves as patients and remain sadly anchored to their illness, which more and more overshadows their entire life. People who have not been hit by MM firsthand could present themselves as a caregiver to an MM patient or as someone who has lost his/her loved ones because of this disease. In both cases, the individual tends to assume the role of victim and to withdraw into himself/herself, retreating in advance from social relationships and from life [15, 16].

THREATS TO THE SOMATOPSYCHIC UNIT

Like other fatal cancers, MM is a threatening event that finds patients and families unprepared both in their bodies and in their minds. This kind of oncologic disease, in fact, is an organic process with devastating consequences in the soma. The rapid growth of the disease leads in a very short time to an uncontrolled growth of tumor cells covering the organs. For example, in the most frequent form of MM (i.e., malignant pleural mesothelioma; MPM), we observe the proliferation

of tumor cells on the pleura, a thin membrane that lines the lungs and chest wall. Common physical symptoms are intense pain in the lower back or in one side of the chest, chronic fatigue, cough, difficulty swallowing, and fluid in the lungs that impedes the patient's breathing, leading to an intimate sensation of suffocation.

Each change in the soma reflects specific changes in the mind of every single person. Thus, sensory, somatic, and emotional experiences linked with the disease are embodied and experienced primarily at a bodily level. These experiences are related to affects, thoughts, defenses, and fantasies, which most of the time are unconscious because of their quality and the lack of a psychic structure able to represent and symbolize them. In clinical work, it is quite common to observe that physical symptoms are very restricting for MM patients, and little by little they expose the ill subject and his/her interpersonal entourage to the loss of integrity and autonomy. Unable to digest what is happening to them or to their loved one, people feel scared, angry, and alone when faced with a sick body they do not recognize anymore because of new limitations and needs they are not able to manage [15, 17]. Thus, the soma – and its status of an ill soma – becomes the source of intense anxiety, conflicts, and fantasies connected to death.

A primary defense strategy used to exclude from awareness the painful contents arising from such a terrifying physical condition is to split the soma and psyche, denying the amount of affect connected to the mental representation of the disease. However, in that way the patient alienates himself/herself from the psychological experience he/she is living and from the reality of affects, thoughts, and fantasies connected to the ill body and the idea of death. This strategy, on one hand, allows a patient to keep on going as if nothing has happened, but on the other hand, it exposes both patients and caregivers to a dangerous regression that could lead to a gradual freezing of their affective and relational lives and, in the most serious cases, to actual disaggregation.

A clinical manifestation of this process is the absence of emotion in the spoken narrative of a great number of MM patients and caregivers and their difficulty in describing the fears, anxieties, despair, guilt, shame, and rage about their unfair fate [18-20]. In the desperate attempt to preserve a wounded identity and to harbor the illusion that nothing of this kind could ever happen to them, often families touched by MM may underestimate its prognosis, denying the undeniable fact that mesothelioma is fatal, dissociating painful emotions related with the disease [21]. Nevertheless, behind the difficulty of speaking openly about deadly experiences and affects linked to MM, we could trace the fantasy of aerial contamination by an invisible killer that was shared by the majority of the citizens in Casale Monferrato – and not only the ones who worked at the Eternit [10, 16].

HELPING PEOPLE LIVING IN A CONTAMINATED SITE THROUGH A BRIEF PSYCHOANALYTIC GROUP THERAPY (BPG-CS)

One of the most important characteristics of the mind of a psychoanalyst is elasticity and the capability

to adapt psychoanalytic technique to the specific context he/she has to face without losing sight of the theoretical model from which the therapeutic methodology originates [22]. Despite the great importance given to free associations and interpretations in the “classical” psychoanalytic relationship, according to Bion [23], one of the key functions of the psychoanalyst is to promote symbol production. We strongly believe the psychotherapeutic work in CSs has to include both of the previous theoretical considerations. Taking into account the limited life expectancy of patients with MM, its rapid progression, and the patients’ critical condition in the terminal phase of the disease, it could be useful to offer a time-limited clinical intervention in the first months following the diagnosis.

Moreover, given the traumatic somatopsychic experiences those patients are living and the echo they have in their relationship within the family, a psychoanalytic group intervention for all the family members may constitute a valid contribution to the integration and elaboration of unconscious somatopsychic processes related to death anxieties. Thus, for those who are unable to find an inner space for the disease to digest what is happening in their lives, and who feel scared and alone in the face of the traumatic idea of loss and death, the group could be conceptualized as a transformational system with an operational aim: generating new thoughts and giving meaning to dissociated traumatic experiences that have hardly ever been conscious. In this space, participants project violent and painful emotions and ideas related to their traumatic reality that thereby acquire the conditions for representability and become translated into thoughts and words [15, 17]. Nevertheless, the group is not only a container for the destructiveness arising from “amplified” negative emotions, but it is also a source of generative potentialities, a container for yet unidentified elements that become raw materials for the growth of awareness and autonomy [24]. The therapeutic effects produced by group therapy originate from a sort of “mutual compensation” coming from the interactions between families that show different psychological and relational functioning [12, 25]. By “mutual compensation” we mean the positive effect gained by the members of the group as a result of the experience within the group that exists in different ways – more or less adaptive – to react to the same disease both from a psychological and a physical point of view.

For those reasons, we developed a Brief Psychoanalytic Group therapy (BPG) for both patients and caregivers with the idea to contribute to ameliorating the quality of their internal and external relationships amid such suffering. It comprises 12 one-hour weekly sessions in a psychoanalytic group specifically designed for the first months following the diagnosis, which seem to represent a highly traumatizing time during which subjects go through intense experiences of disintegration, splitting, and post-traumatic conditions [18, 19]. Therefore, we assumed that offering a therapeutic intervention in this period could help the participants to face and symbolize the specific emotional framework, which becomes the content of the sessions (e.g., fear of dying/

becoming ill, shame, feeling of injustice for the damage suffered, guilt, rage) [15, 17].

Since 2014, we have realized three BPG interventions in the NPCCS of Casale Monferrato. The interventions involved 53 participants: 29 MM patients and 24 caregivers, aged from 22 to 77. Twenty-eight were women, 25 men.

Within the next pages, the intervention model will be described, with regard to *setting*; *participant selection*; *preliminary interviews*; *group therapy features*.

Setting

The model proposed to provide 12 one-hour weekly sessions. The sessions took place at the Alessandria and Casale Monferrato Hospitals and were led by two psychoanalytic-oriented psychotherapists trained for clinical work with oncologic patients and in the conduction of psychoanalytic-oriented groups. We chose to use co-conduction to guarantee a better focus on the unconscious emotional contents and implicit communications, thus increasing the possibilities to consider at the same time the intrapsychic, intrafamily, and interpersonal dynamics active in the group.

Participant selection

Because of the lack of evidence of the effectiveness of the model proposed, we used inclusion and exclusion criteria as a prelude to future research.

The inclusion criteria were as follows: having been diagnosed with MM/having been the caregiver of an MM patient for 6 months at most; high motivation to participate in group therapy all along the entire intervention; having reached the age of majority.

The exclusion criteria were as follows: having a certified psychiatric diagnosis; having a certified diagnosis of neurodegenerative disorders (Alzheimer, Parkinson, etc.); having pronounced paranoid personality traits; undergoing other psychotherapeutic interventions; and having a poor knowledge of the Italian language.

The possibility to access BPG is presented by the oncologist and the psychologist to MM patients and caregivers matching inclusion/exclusion criteria. Clinically, we have observed a high risk of dropout, mostly related to the worsening of the patients’ conditions, the decision to be treated in another center, or difficulty tolerating the contact with painful emotions. Thus, we set a minimum number of 15 participants before the BPG starts.

People suitable for the BPG undergo one or more preliminary clinical interviews with the group co-conductors before the beginning of the intervention.

Preliminary interviews

Prior to the BPG, the psychotherapists lead a clinical in-depth interview with the persons willing to participate. During such interviews, clinicians (a) inform the future participants about the group setting; (b) explore the main thoughts, affects, and defenses related to the oncologic diagnosis; (c) explore the etiology of MM (i.e., occupational vs environmental); (d) investigate the subjective experience of medical treatments; (e) evaluate their suitability for a group setting. If dur-

ing the interviews clinicians consider patients and/or caregivers not sufficiently interested in reflecting upon the functioning of their own mind or more suitable for other interventions (i.e., individual ones), they transfer the patient/caregiver to the psychological service at the hospital involved.

In the presence of highly traumatized people, clinicians may find it necessary to have more than a single interview to further investigate some diagnostic elements and, at the same time, to facilitate the construction of a therapeutic alliance, decreasing the persecutory aspects that often arise in these patients. If the psychotherapists conduct more than one interview, they can ponder whether to meet the participants individually (the patient alone or the caregiver alone) or in the same spontaneous configuration of the first meeting.

Group therapy features

Like other forms of brief psychoanalytically oriented interventions, the BPG-CS consists in different phases, each of them with specific aims and tasks [26].

Initial phase (sessions 1 to 3)

In the first phase, clinicians work through physical repercussions related to a new medical condition (e.g., restrictions, physical transformations), integrating them with painful feelings that are often hard to express for the patients and for their families. During the first three sessions, throughout the narratives shared in the group, the leaders explore how people relate to an ill body and to its new limitations and needs, along with the desires, anxieties, and unconscious affects related to the danger of living in a CS.

The group thinks together about the emotional turbulence that each member is undergoing, and the psychotherapists highlight differences and similarities between the participants, especially between patients and caregivers. This last aspect allows participants to identify some common nodal problems and to experience a sense of communion that goes beyond the different health conditions.

The main aim of the first phase is to identify a shared and recurring topic inside the group that combines the impact of physical symptoms with emotions, feelings, and fantasies related to the disease (*somatopsychic focus*; *SPF*). The intensity of anxiety toward the future (i.e., life/death) can compromise the symbolic perspective of the patients and their caregivers by leading to a concrete and stalled mental functioning and to the narrowing of thoughts around death and the disease, which ends up exacerbating affects connected to loss and mourning. It can easily happen that the experience of the oncologic disease and its practical repercussions on everyday life and relationships are actively denied, so that no conscious traces can be found. In other words, there is a lack of full comprehension of what has happened and is happening, of the restrictions brought by the oncologic disease, and of its practical and emotional repercussions. By using more symbolic language and metaphors, the co-conductors facilitate the identification of a shared image/metaphor to which the group gives a title. The identification of this theme allows the participants,

in the following phases, to explore the forces, the mental states, and the interpersonal difficulties/perceived threats to relationships (e.g., loss/separation).

It is assumed that the focus underpins specific inner representations, mental states, and interpersonal functioning related to present symptoms and disease. For example, the SPF emerging in the first group was *village dancing*, a regular custom and concrete experience shared among many participants. Starting from the different impacts of the disease, it was possible to explore that despite the fact some were still able to dance, they do not dance anymore, while a few could not dance because of their clinical conditions. Through the exploration of the group members' narratives, stimulating their free associations on the focus and connecting the concrete speech of symptoms to their emotional life, it would be possible to identify the restrictions imposed by the cancer and the thoughts and affects related to it: pain and fear related to the loss of important facets of life ("I don't dance anymore"); the fear of not being able to do what they used to do before the disease ("I'm not able to dance anymore"); the difficulties experienced in the encounter with others, leading to the rejection of loved ones ("I don't want to dance with you anymore").

Central phase (sessions 4 to 8)

In the second phase the co-conductors help the group to work through the SPF. During this phase, it is important to maintain the focus on the agreed SPF, helping members to recognize their inner states (e.g., feelings, thoughts, fantasies, desires) and connecting them to daily events, medical treatments, and new emerging symptoms. The co-conductors bring the explicit and implicit contents back to the SPF; they actively promote the ability to reflect upon one's own mental states and actual experience, naming defensive and dysfunctional patterns they are relying on (i.e., type of defenses, functions, features, psychic cost). While in the group one psychotherapist puts into words unsymbolized painful feelings and thoughts, the other highlights the similarities between what happens in the group and what happens at home in terms of relational dynamics. This constant transformational work from a practical to a symbolic dimension allows participants to increase awareness, to contain and give meaning to the suffering and the dysfunctional relational patterns. Thus, participants are helped to become more aware of their own emotional reactions to bodily modifications and of the consequences to their social and intimate relationships.

Furthermore, the therapists explore individual and group resources, promoting the development of more mature and adaptive strategies to face the difficulties related to the illness journey.

For example, referring back to the first group, the SPF of *village dancing* also recalled the desire to keep one's vitality and agency alive through the disease, to keep feeling one's own body and finding pleasure in moving following the rhythm of music. Starting from those associations, it has been possible to move from a position of anticipated withdrawal and rejection toward the desire to "keep on dancing". Thus, the co-conductors have been able to work to promote the possibility



of emotional transformations that could open the way for the creation of the conditions that allow participants to translate the desire into action (“having one more dance”).

Conclusive phase (sessions 9 to 12)

The last four sessions are aimed at helping the group go over its story (disease, absences/deaths, resources, common strategies), explore conscious and unconscious fantasies about the meaning of the end of the therapy, and identify what each member will bring home of the work done together. The co-conductors invite the participants to retrace the most meaningful moments and images of the psychotherapy journey and the main transformations of intrapsychic, interpersonal, and group dynamics.

The emotions and painful life events shared with the group, as well as the new relational bonds promoted by the group work, are an important legacy that somehow anticipates the future losses and the related difficulties to come. The process of historicization of emerged topics allows participants to put this legacy into words, along with the shared journey and with the transformations painstakingly achieved, restoring in that way a basic confidence in one’s own resources and in the possibility to resist life shocks without falling apart.

The conclusive phase of the first group was focused, for example, on the will to live and on the importance of still feeling alive among the living. Some sort of radio-vitality eventually grew over the meetings, an attempt to move forward all together step by step, as if the group were a conga line and each one, in turn, had the chance to experiment in the position of leading the machine, having the strength to give vitality to the others.

CLINICAL CONSIDERATIONS

In the three reproductions of the BPG intervention, we have noticed that patients usually presented themselves as victims and wanted to tell how they found out about the disease, while caregivers mostly presented themselves as the patients’ silent companions. This tendency is quite often observed in clinical settings and is related to intense feelings of guilt and shame because the healthy people will survive and they feel they are not worthy of naming their own suffering [27]. Clinical work with those subjects should be aimed at helping them to break free from their role of patients and/or asbestos victims and to retrieve the possibility to think of themselves as individuals, despite the disease. We strongly believe that a key step for the acquisition of a fostered vitality is the reconstruction of the missing links between soma and psyche broken down by the trauma of the oncologic diagnosis.

To promote the connection between the physical facets of the disease and internal and interpersonal functioning, it could be useful to start from the physical symptoms, the historicization of the MM, and medical treatments. In fact, usually for both oncologic patients and caregivers it was easier to speak about the disease through symptoms and focusing on concrete medical treatments they were undergoing, avoiding and distancing themselves from disturbing emotions and thoughts

related to cancer. During group sessions, it was quite difficult for MM patients and their caregivers to talk about their subjective experiences of the disease and name its repercussions on daily life and relationships. The struggle to tie one’s shoes, the labored breathing, and the impossibility to recover had often been described in the same emotional tone used to describe routine activities like buying groceries or reading the paper. During the group sessions, participants shared the story of their disease: how they got to the MM diagnosis. This came unexpectedly both for the patients and for their families – life-changing shock that marks a rough transition from which there is no coming back. As Freud pointed out [28], under traumatic circumstances, the flow of time can sometimes collapse, leaving the individual stuck to the traumatic event and thus prematurely withdrawing from life. Little by little, their entire life loses its appeal and attractiveness, becoming a sort of black-and-white photograph.

At a clinical level, this tendency reveals a frozen emotional life and the use of massive defense strategies to face the traumatic idea of MM and its consequences. This quite common strategy could be summed up in Ettore’s words, “I don’t think about it”, which became a mantra for the other members of the second group. Nevertheless, not thinking is a dangerous strategy that protects patients from traumatic experiences, but at the same time compromises their capability to deal with their conditions for what they really are (i.e., reality testing) [29]. For example, a participant in the first group suffering from MPM – Bruno – was used to getting involved in competitive races, a physical activity that implies good lung capacity, which was impaired by the illness. The clinical work helped Bruno to scale back the unrealistic desire to live exactly the life he had before the disease and to reduce his massive use of denial. Thus, it became possible for him to continue to get involved in a pleasure activity (running), but in a more realistic way, moving away from competitive circuits while allowing himself running routes adapted to his actual physical and psychological conditions. For Bruno this meant keeping enjoyable and lively spaces in his life, notwithstanding the disease, and at the same time allowing himself to walk, sometimes, and not always run, to rest to catch his breath, thus adapting his actions to his biorhythms.

In the BPG interventions, two of the Authors (FVB and MG) found themselves in front of recurring questions: “Why is this happening to me?” “Why me, since I never worked at the Eternit factory?” “Could I be the next one?” While the first questions are normal in the work with oncologic patients and reflect the need to make sense of the traumatic vicissitudes within their personal life and to give meaning to the disease [30], the last one assumes a specific configuration related to life in an NPC. In fact, living in or near a CS implies a ghost of death that always stays in the background, and that makes people ask when their time is coming [16]. We found those same aspects in the second group when Giovanna, a patient’s wife, discovered she also had a tumor. This tragic event triggered intense emotions and unconscious fantasies of an aerial contagion that



lingered among the healthy participants, just as it did among the population of Casale Monferrato [10, 16].

In most cases, people arrived at the group very frightened or very angry. Those who were frightened felt lost, without any hope and in need of retrieving information from other participants about what was going to happen to them next in the treatment trajectory. Instead, angry participants often addressed their rage and destructiveness toward situations and people outside the group: asbestos, institutions, diagnosis delays, experimental protocols, the intricate process for the compensation of damages. Consistent with previous clinical work in Casale Monferrato, in the groups a large amount of rage was circulating [10, 15, 17]. Often the rage took the form of criticism toward something external to the group: the medical staff, clinicians, or institutions involved in damage compensation. The projection of destructiveness toward external objects could be seen as a defense from the risk of feeling rage toward something internal (e.g., losing capabilities because of the disease, the upcoming mourning and death, not feeling understood) or to cover up deep depressive feelings (e.g., discouragement, sadness, helplessness). These clinical manifestations of destructive impulses, in fact, are closely related to a profound feeling of helplessness that could not be felt and is actively denied [21]. Yet, denying those feelings implies excluding them from awareness, thus it is impossible to create a symbolized narrative of what is happening. As a consequence, it is not possible to share affects that would reactivate the trauma within the others, compromising the chances to receive help and comprehension. Hence, the patient finds himself/herself overwhelmed by catastrophic emotions he/she is not able to put into words. At the same time, he/she feels highly frustrated because his/her loved ones are not able to recognize these feelings and to help him/her. On the other side, family members can feel prematurely lonely, rejected in their caregiving role, guilty and helpless because they will survive and they are not able to save their loved ones. This relational pattern has also been traced in BPG interventions to a great risk for breaking relational bonds. During the sessions it was important to put into words those underlying emotions, opening the way for their transformations into feelings that could be expressed within each one's

meaningful relationships [31]. The conductors' interventions reduced the conflict within the group and promoted the transformation of the accusatory statement "you don't understand me" to the less persecutory one "I feel bad because I don't feel understood." This way, it becomes possible to handle contents that once were "incandescent" [12] to ask and to receive help and to feel less lonely while living with a fatal disease.

CONCLUSIONS

The clinical model proposed in this paper suggests that it could be particularly useful in those situations where very intense feelings, often removed from consciousness, compromise the possibility to ponder the experience of the disease. Enhanced by the clinical experience in Casale Monferrato, we believe BPG could be a suitable intervention for helping people living in CSs to face traumatic affects and experiences and to restore a sense of vitality in a threatening landscape surrounded by death.

Thinking together within the group helped participants to give meaning to the transformations in their lifestyle brought about by the experience of the disease and the related feelings, to weaken its pathogenic effects, and to identify more adaptive ways of handling the diagnosis. This has been possible thanks to the opportunity to encounter more realistic relational modalities that could include the disease along with the new meanings that had been built around living and dying. The clinical work allowed participants to create the conditions to discuss new plans in accordance with the time left to live and with each one's specific conditions.

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Conflict of interest statement

There are no potential conflicts of interest or any financial or personal relationships with other people or organizations that could inappropriately bias conduct and findings of this study.

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REFERENCES

1. World Health Organization. Regional Office for Europe. Contaminated sites and health. Report of two WHO workshops: Syracuse, Italy, 18 November 2011, Catania, Italy, 21-22 June 2012. Copenhagen: WHO Regional Office for Europe; 2012. Available from: www.euro.who.int/_data/assets/pdf_file/0003/186240/e96843e.pdf.
2. Guglielmucci F, Franzoi IG, Zuffranieri M, Granieri A. Living in contaminated sites: Which cost for psychic health? *Mediterr J Soc Sci*. 2015;6(4 S3):207-14. DOI: 10.5901/mjss.2015.v6n4s3p207
3. Granieri A. La comunità contaminata di Casale Monferrato: aspetti corruttivi della governance e sopravvivenza psichica. In: Ambrosiano L, Sarno M (Eds.). *Corruttori e corrotti. Ipotesi psicoanalitiche*. Milano: Mimesis; 2016.
4. Freud S. Group psychology and the analysis of the ego. In: Freud S. Standard edition of the complete psychological works of Sigmund Freud, Vol. XVIII. Beyond the pleasure principle, group psychology and other works. London: The Hogarth Press and The Institute of Psychoanalysis; 1921.
5. Granieri A. Amianto, risorsa e dramma di Casale. *Risvolti psicologici nelle persone affette da mesotelioma e nei loro familiari*. Genova: Fratelli Frilli; 2008.
6. Granieri A. L'amianto, la double peine. Casale Monferrato: *atteintes physiques, traumatismes psychologiques, résistances*. Fréjus: Sudarenes; 2013.
7. Granieri A, Tamburello S, Tamburello A, Casale S, Cont C, Guglielmucci F, Innamorati M. Quality of life and per-

- sonality traits in patients with malignant pleural mesothelioma and their first-degree caregivers. *Neuropsychiatr Dis Treat.* 2013;9:1193-202. DOI: 10.2147/NDT.S48965
8. Guglielmucci F. *Vita, morte e lotta nel sito contaminato di Casale Monferrato. Alcune riflessioni tra clinica e ricerca.* Genova: Fratelli Frilli; 2016.
 9. Granieri A. Community exposure to asbestos in Casale Monferrato: From research on psychological impact to a community needs-centered healthcare organization. *Ann Ist Super Sanità.* 2015;51(4):336-41. DOI: 10.4415/ANN_15_04_14
 10. Borgogno FV, Franzoi IG, Barbasio CP, Guglielmucci F, Granieri A. Massive trauma in a community exposed to asbestos: Thinking and dissociation in the population of Casale Monferrato. *Br J Psychother.* 2015;31(4):419-32. DOI: 10.1111/bjp.12170
 11. Franzoi IG, Guglielmucci F, Borgogno FV, Granieri A. Il caso Giulia. *Psicoterapia e Scienze Umane.* 2015;XLIX(4):656-64. DOI: 10.3280/PU2015-004007
 12. Granieri A, Borgogno FV. Pensabilità e dissociazione in una popolazione colpita da trauma massivo: Una ricerca intervento di matrice psicoanalitica. *Il Vaso di Pandora. Dialoghi in psichiatria e scienze umane.* 2014;22(2):83-102.
 13. Varvin S. Psychoanalysis with the traumatized patient: Helping to survive extreme experiences and complicated loss. *International Forum of Psychoanalysis.* 2016;25(2):73-80. DOI: 10.1080/0803706X.2014.1001785
 14. Rozenfeld A. La resilienza: una posizione soggettiva di fronte alle avversità. *Prospettive psicoanalitiche.* Genova: Fratelli Frilli; 2014.
 15. Granieri A. Extreme trauma in a polluted area: bonds and relational transformations in an Italian community. *International Forum of Psychoanalysis.* 2016;25(2):94-103. DOI: 10.1080/0803706X.2015.1101488
 16. Guglielmucci F, Franzoi IG, Barbasio CP, Borgogno FV, Granieri A. Helping traumatized people survive: a psychoanalytic intervention in a contaminated site. *Front Psychol.* 2014;5:1419. DOI: 10.3389/fpsyg.2014.01419
 17. Granieri A. The drive for self assertion and the reality principle in a patient with mesothelioma: the history of Giulia. *Am J Psychoanal.* 2017;77(3):285-94. DOI: 10.1057/S11231-017-9099-0
 18. Arber A, Spencer L. It's all bad news': The first 3 months following a diagnosis of malignant pleural mesothelioma. *Psychooncology.* 2013;22(7):1528-33. DOI: 10.1002/pon.3162
 19. Guglielmucci F, Franzoi IG, Bonafede M, Borgogno FV, Grosso F, Granieri A. "The less I think about it, the better I feel": a thematic analysis of the subjective experience of malignant mesothelioma patients and their caregivers. *Front Psychol.* 2018;9:205. DOI: 10.3389/fpsyg.2018.00205
 20. Hughes N, Arber A. The lived experience of patients with pleural mesothelioma. *Int J Palliat Nurs.* 2008;14(2):66-71. DOI: 10.12968/ijpn.2008.14.2.28597.
 21. Straker N. Psychodynamic psychotherapy for cancer patients. *Psychother Pract Res.* 1998;7(1):1-9.
 22. Ferenczi S. The elasticity of psycho-analytical technique. In: Ferenczi S. *Final contributions to the problems and methods of psycho-analysis.* London: The Hogarth Press and The Institute of Psychoanalysis; 1928/1955.
 23. Bion WR. *Transformations.* London: William Heinemann; 1965.
 24. Neri C. *Gruppo.* Roma: Borla; 1995.
 25. García Badaracco JE. *Psicoanálisis multifamiliar. Los otros en nosotros y el descubrimiento de sí mismo.* Buenos Aires: Paidós; 2000.
 26. Lemma A, Target M, Fonagy P. *Brief dynamic interpersonal therapy: A clinician's guide.* Oxford: Oxford University Press; 2011.
 27. Fornari F. *Affetti e cancro.* Milano: Raffaello Cortina; 1985.
 28. Freud S. Mourning and melancholia. In: Freud S. *Standard edition of the complete psychological works of Sigmund Freud, Vol. XIV: On the history of the psychoanalytic movement, papers on metapsychology and other works.* London: The Hogarth Press and The Institute of Psychoanalysis; 1915/1917.
 29. Freud S. Formulations on the two principles of mental functioning. In: Freud S. *Standard edition of the complete psychological works of Sigmund Freud, Vol. XII: "The case of Schreber", "Papers on technique" and other works.* London: The Hogarth Press and The Institute of Psychoanalysis; 1911-1913.
 30. Chiozza LA. *Why do we fall ill? The story hiding in the body.* Madison, CT: Psychosocial Press; 1986/1999.
 31. Granieri A. *Corporeo, pensiero, affetti. Intreccio tra psicoanalisi e neurobiologia.* Torino: UTET; 2011.