MULTIFAMILY GROUPS IN MENTAL HEALTH

Erasmus+

Project n. 2021-1-IT01-KA220-VET-000033303

COMPETENCES AND TRAINING OF THE CONDUCTOR AND THE FACILITATOR OF MULTI-FAMILY PSYCHOANALYTICAL GROUP

Co-funded by the European Union

ASL ROMA 1

UPC KU LEUVEN

APF

AIDFM

"Competencies and training of the Conductor and Facilitator of the Multifamily Psychoanalytic Group" represents the result of the study on the components characterizing a training program on multifamily psychoanalysis groups in Italy, Belgium, Spain and Portugal. This volume collects the documents developed in the second phase of the "Multifamily Groups in Mental Health" (FA.M.HE.) project, financially supported by the European Union through the Erasmus+ Programme.

The five partners of the project collaborated in its development: “Laboratorio Italiano di Psicoanalisii Multifamiliare” of Rome as Project Coordinator, “Associação para Investigação e Desenvolvimento da Faculdade de Medicina” of Lisbon, “Azienda Sanitaria Locale Roma1” of Rome, “Asociación de Psicoterapia Psicoanalítica de Pareja, Familia y Grupo Multifamiliar ' of Bilbao and “University Psychiatric Center Z.ORG KU” of Leuven.

INDEX

PREFACE

“Competencies and Training of the Conductor and Facilitator of a Multifamily Psychoanalytic Group” is the product of various levels of knowledge and processing. Over nearly two years, the five project partners of “FA.M.HE. ” have interwoven and connected their insights through:

- The analysis of the characteristics and the spread of multifamily groups across the four involved countries;
- Shared considerations and reflections by the international participants over the course the Project itself during these two years;
- Cumulative training experiences accrued by the partners over many years.

The ultimate goal was to co-construct a Training Program in Multifamily Psychoanalysis that adheres to the epistemological framework while ensuring the effectiveness, reproducibility and verifiability of the training courses across various European socio-healthcare contexts.

The Training Program specifically caters to the two pivotal and interdependent roles active in therapeutic work with Multifamily Psychoanalytic Groups: the Conductor and the Facilitator.

The document is primarily targeted at professionals working in the healthcare sector including psychiatrists, psychologists, nurses, social workers, educators as well as families interested in mental health. However, the methodology described is also applicable in other scenarios where there is a need to resolve relational or institutional conflicts. As such, it can also be useful for professionals in educational, judicial and social fields.

In this Preface, we provide a concise overview of the three documents that form the chapters of this volume. Developed by our partners over recent months, these documents have been integrated to define the training course in Multifamily Psychoanalysis. This structure aims to illustrate the progressive development of the methodological framework underlying the training proposal.

The **FIRST PART** features a Vademecum on the key concepts of Multifamily Psychoanalysis.

This Vademecum was inspired by the ideas of J. García Badaracco and enriched by contributions from partners in the participating countries, coordinated by the “Asociación de Psicoterapia Psicoanalitica de Pareja, Familia y Grupo Multifamiliar” of Bilbao. The document’s content was crafted by the five project partners during a transnational workshop in Rome in November 2002 and refined in subsequent online discussions.

Multifamily Psychoanalysis (MFP) represents a new paradigm in the therapeutic approach to mental suffering, evolving its theoretical conceptualization and methodological framework through a continuous dialogue between clinical practice (the Multifamily Group as a laboratory and hotbed of ideas) and theory (set of hypotheses, product of this clinical practice)

The Vademecum emphasizes the integration of theory, methodology, and clinical practice that defines our philosophy of care and intervention, offering innovative methods for creating a therapeutic environment marked by safety, solidarity, and trust.

The document describes the theoretical foundations of the intervention, the practical recommendations for conducting a GMF and the curative elements of the multifamily intervention.

The **SECOND PART** delineates the "MFPG Conductor Competencies System: from families of competencies to coherent behaviours".

This document, coordinated by the "Laboratorio Italiano di Psicoanalisi Multifamiliare" in Rome, was finalized with inputs from all partners and approved at a Transnational Meeting in Bilbao in October 2023. It describes a matrix of competencies for the Multifamily Group Conductor and Facilitator, starting with the specific professional competencies required for the role compared to other psychotherapeutic figures. Indeed, The Multifamily Psychoanalytic Group represents a robust therapeutic approach, and it is critical to acknowledge and meticulously manage its potential risks and challenges to ensure both effective and safe treatment for all participants. Mitigating these risks and ensuring the success of the therapeutic group hinges crucially on the competencies and training of the Conductor. This document emphasizes that the Conductor's role extends beyond mere possession of theoretical knowledge. It underscores the importance of a broad array of cross-disciplinary therapeutic competencies, which are vital for structuring the unique multifamily setting. These competencies can be acquired and enhanced by all members of the conductive team, ensuring a comprehensive approach to patient care.

Through the definition of the concept of competence, specific "families" of competences have been organized. These are homogeneous sets of behaviours that relate to similar knowledge and competencies, shaping the behaviour of the Conductor and theFacilitator within the specific "setting". The process of describing observable behaviors in each family of competences, summarized by the expression "know-how", has enabled the development of the competency matrix for the Conductor. The acquisition and development of these competencies help to ensure the effective functioning of the Group.

The **THIRD PART** proposes the "Training program for Conductors and Facilitators of Multifamily Psychoanalytic Groups"

The contents of this document were defined during a transnational meeting among partners in Bilbao and further developed and approved with contributions from all project partners during dedicated transnational meetings. The "Laboratorio Italiano di Psicoanalisi Multifamiliare" coordinated its development and final drafting.

Building on the training expertise acquired over the years by the Project partners, the experience of LIPsiM in the field of teaching and training was explored, which represented a first attempt to formulate a formal learning path consistent with the fundamental assumptions of the PMF.

Subsequently, the reflections that emerged during various moments of exchange and discussion between all the partners, sometimes outside the formal program of the meetings, occasionally as spontaneous "brainstorming" and other times as an experiential narratives, were systematized. Together, these formed the valuable framework on which to co-construct all the products envisaged by the Project.

Starting with the definition of the professional figures it targets, the Conductor and the Facilitator of the Multifamily Psychoanalytic Group, the training project is described. It is structured into three consecutive years, each of which allows the acquisition of specific competencies/competences of each figure. The most characterizing elements include the first training step for the Facilitators, shared by all professional roles foreseen in the Mental Health Services, and the centrality of the direct participation of all students in a Multifamily Group with a teaching function throughout the duration of the training experience. The last part is dedicated to defining a modular program adaptable to the different socio-healthcare realities present in Europe but at the same time effective, verifiable and reproducible.

PART ONE
"VADEMECUM - THE KEY ELEMENTS OF CONDUCTING/FACILITATING MULTIFAMILY PSYCHOANALYSIS GROUPS" - BASED ON THE THEORY OF JORGE GARCÍA BADARACCO

INTRODUCTION

The Multifamily Psychoanalytic Group (MFPG) is an effective therapeutic space and has become a socio-experiential laboratory that allows, through the sharing of experience and interaction between group members, the approach and treatment of a heterogeneous population composed from families with different pathologies.

MFPG's are composed of at least two generations including the person receiving specific mental health care.

It is a large, open or semi-open group, which is formed gradually and can gather from 10 to more than 100 people.

It replicates a sample of our society (mini-society) with families from different cultures and socio-economic levels, who participate in a common experience, where they share their anxieties and distress and can face their difficulties in an atmosphere of security and trust.

The group is led by mental health professionals who work in co-therapy and constitute a multidisciplinary therapeutic team.

The group session usually takes place weekly or fortnightly, lasting between 90 and 120 minutes.

In the late 1950s, J. García Badaracco returns to Buenos Aires and carried out a series of experiences in a chronic patient service of the Neuropsychiatric Hospital José T. Borda in the city of Buenos Aires.

Having completed his psychiatric and psychoanalytic training in Paris, and influenced by the ideas of Maxwell Jones in Therapeutic Community and by French Institutional Psychotherapy, he dedicated himself to applying psychoanalytic knowledge to severe mental pathology.

To do so, he used a methodology that he called "recontextualisation", which consisted in the validations of the contributions from the different psychoanalytic schools, through observation and application of their concepts in a broader context (therapeutic community and multifamily group). Lack of means, organizational difficulties and some exceptional situations led him to bring together, on a daily basis, all the patients of the service, their relatives and the professionals working with them.

Thus, the first multifamily groups were born, which became a social-experiential laboratory, where the interaction between the members of the multifamily group allowed us to observe psychological phenomena not previously described in the psychoanalytic clinic.

> *The multifamily group allows for the observation of the three dimensions of the mind, i.e. individual, family and social, and generates a unity of analysis that allows for a broader understanding of the inner psychic world and its interaction with the outer world, which manifests itself in Reciprocal Interdependencies.*

The concept of Reciprocal Interdependencies has gained relevance over time that, with Healthy Virtuality, Genuine Ego Resources, Therapeutic Process, Maddening Object (maddening presences) and others, has become one of the foundations that gaves rise to a new paradigm: the Multifamily Psychoanalysis.

Over the course of more than sixty years, the theoretical conceptualization and methodological contents of this paradigm have been explored in depth, through a dialectical continuum between clinical practice (the MFPG as a laboratory) and theory, as a set of hypotheses, product of this clinical observation.

This introduction highlights the contents of theory, methodology and clinical practice, which define a philosophy of care.

Multifamily psychoanalysis is an original and creative frame of reference that allows (re)thinking about healthy development, the pathological organization of mental suffering and the treatment pathways of serious and/or chronic patients.

Unlike other psychoanalytic modalities, this way of working has a specific methodology in terms of framing, managing the transfer, creating an emotional climate of security, trust and solidarity and how to intervene through conversation. All this is the product of a complex thought, which we will try to present in this Vademecum.

Possibility of Treatment

Contrary to what happens in biological-organic based psychiatric guidelines which foresee the "management" of symptoms in a perspective of a more or less partial "normalization" of the "patient", Multifamily Psychoanalysis proposes to work with people and relationships in transformative sense, starting from the unexpressed potential – healthy virtuality – rather than from the pathological elements.

> *Everyone is seen as a potentially healthy person rather than a sick person, and exist a possibility of treatment, even in the most serious and/or chronic situations.*

The way of looking at a person is closely connected with what one imagines of the other, the gaze is not discussed, it penetrates directly into the unconscious and emotionally connotes the relationship.
The fear, the bewilderment, the senselessness present in the gaze of the other, in particular of a psychiatrist, can have an enormous pathogenic power on a person who is already frightened and bewildered by what is happening to him while feeling looked at as someone who possesses potential hidden generates hope and trust from which to start healing.

An incredible number of sufferings derive from incomprehension, misunderstanding, unconscious cruelty in relation to the other, especially the closest; the crisis can be seen as a desperate attempt to bring out the healthy, individual and relationship potential, an opportunity to introduce change and transformation in the family traps of suffering.

In the same way, the different symptomatological states can be considered concrete languages to express otherwise inexpressible needs and emotional states, exaggeration of normal processes and expression of an invisible potential.

The possibility of cure and recovery is structured around the possibility of tolerating the complex displacement between certainty and uncertainty, order and disorder, coherence and contradiction: regressions and relapses are not a sign of "incurability" but represent inevitable moments of verification in dealing with new situations.

Mental suffering occurs in the relationship between two or more people

Mental suffering always manifests itself in pathogenic relationships between two or more people. The development of these relationships is usually the result of unconscious, sometimes secret and hidden plots, which reveal the existence of a mutual interdependence.

It is possible to detect the presence of these plots in all human conflicts; in this sense, mental suffering can be considered as the particular expression of a reciprocal, pathogenic and pathological interdependence.

When we think of mental illness, we usually refer to psychopathology as something belonging to the individual sphere, denying the interactive exchange between mind and environment, i.e. excluding the relational reality.

The potential for personality growth and development is always present in the human being, and it represents the healthy virtuality; it is the pathogenic and pathological interdependencies, operating from the external or internalised reality ("the others in us"), that interfere with subjectivity and prevent the development of a "true self".

In other words, both the external world and the internal world strongly influence the possibility of people becoming integral individuals, legitimised and recognised in their own subjectivity. J. García Badaracco said: "... in this sense, we could say that madness is always and ultimately a folie a deux".

Therapeutic process

The broad notion of the therapeutic process includes the idea of how a person and his or her family become ill and the path they must follow in order to be cured.

We understand mental illness as the arrest of the growth and development of the personality, in which biological, psychological and social factors are involved.

The therapeutic process is a clinical concept by which we refer to the set of transformations that the person and their family can experience through psychotherapeutic treatment.

The idea of process refers to the succession of psychic changes that are presented as varied realizations, with an internal coherence and a progressive sense towards a human condition that we try to formulate as personality maturation, emotional equilibrium, etc.

These changes are objectified in concrete awarenesses that alter the interpersonal relationships and the subjective experiences that transform the internal world and result in structural changes in the personality.

This succession is not linear, nor does it have a single cause, and is characterised by moments of deconstruction and re-composition of the parts of a whole.

> *The therapeutic process has the aim of re-establishing the process of growth and normal development of the person which, due to different factors, was interrupted and distorted during its evolution.*

In the course of the therapeutic process, the patient has to go through phases that he could never go through in his family life.

The new experiences will enrich and strengthen the ego, providing it with the genuine resources necessary to face the identification processes that will modify the structure of the personality.

The therapeutic process is necessarily individual, and therefore unique for each person; its characteristics depend on the clinical picture, how the disease started and its course. Family and social circumstances are strongly influencing factors.

1. THEORETICAL FOUNDATIONS

1.1. Reciprocal Interdependencies (R.I.)

> *Human beings are born, grow and develop in a network of interdependent personal relationships, which constitute the key phenomenon of social interaction, giving rise to the processes of growth and personality development that occur throughout life.*

This network of R.I. takes on a special significance in the clinical work of the MFPG.

Human phenomena are very varied and difficult to encompass in a unified theory of mind and complexity acquires such relevance that it offers us a kaleidoscopic view of psychic events.

The notion of R.I. allows us to include this complexity, which begins at birth and continues throughout life, where the identification processes that give rise to the structure of the personality will take place.

On the one hand, the R.I. allow us to visualize the pathology of the inner world as an "inner dialogue" between the *oneself* and the "others in us" (living presences). These "presences" “speak" to the individual, threatening, despising, criticising and mistreating him (pathological and pathogenic interdependencies).

On the other hand, these situations are simultaneously externalised in relationships; and it is possible to observe how these interdependencies are structured and sustained over time, generating suffering and frustration.

This theoretical position transcends attachment, since it incorporates into its study of the internal world ("psychic reality"), the relationship with the significant other (“intersubjectivity”), and the social factors that influence people's lives (“trans-subjectivity”), emphasising the interactive dimension ("material reality").

> *J. García Badaracco classified Reciprocal Interdependencies into two categories: those that favour the growth and development of the personality (normogenic) and those that interfere with this process (pathological and pathogenic). The quality of these interdependencies will give rise to the real resources of the Ego, on which the resolution of the different internal or external conflicts will depend.*

Working with R.I. leads us to address the plot and interconnections in which the individual is immersed, the dilemmatic conflicts and the "living presences" that inhabit him and continue to act in his internal world and determine the quality of relationships with others.

The MFPG favours the "recovery" of situations in which the patient and the family are trapped and which perpetuate the illness and aggravate pessimism about a better life.

1.2. Healthy Virtuality (Virtualidad Sana)

In J. García Badaracco's theory, Healthy Virtuality is a key concept that refers to the growth and development potential of the personality.

It is based on H. Maturana's concept of "autopoiesis" (1973), understood as the fundamental property of living systems whose interaction with the outside world depends on their own structure to reproduce and maintain themselves.

> *According to J. García Badaracco, "healthy virtuality" is related to the ability of the mind to neutralize and disarm the "maddening presences" in its internal world and to resolve the pathogenic interdependencies of its external world (self genuine resources).*

By focusing on symptoms, psychiatry sees the patient only as "mad or sick" person, and leads them to re-enact the behaviour that, for various reasons (anxiety, fear, frustration and sometimes aggression), they have in their families, leading their relatives to react almost always in the same way.

As a result, the healthy virtuality of the patients is ignored, i.e. the potential for growth and development that exists in every human being, no matter how ill they are.

J. García Badaracco emphasises the power of the gaze in the psychotherapeutic work and the power of the gaze, then, acquires a special meaning: "the patient will feel as we look".

The gaze is not discussed; it penetrates the unconscious and connotes the relationship emotionally.

Therefore, the gaze of the therapist can have an enormous pathogenic power by not glimpsing this potential for growth and personality development.

The possibility of seeing him as a person with this potential generates the hope necessary to adhere to the treatment and start its therapeutic process, as a path to healing.

This allows the family to begin to live the situation with "different perspective".

> *The concept of "healthy virtuality" can be at the heart of a profound revision of both the positive development and the genesis of mental illness. At the same time, it can be seen as a guiding element for understanding the lives of patients and their families, from which the treatment of the most disabling psychiatric disorders can be developed. In fact, the development of healthy virtuality through new genuine resources of the self supports tolerable and possible change.*

This concept also refers to the image of an original and primordial matrix of potentialities which can be manifested, recognized and nurtured, in a favourable emotional and relational environment. The complex trans-generational network of mutual interdependencies plays a fundamental role in creating an conducive environment for the emergence of genuine personal resources that can be reconstituted within a MFPG, rectifying the pathological organization that prevailed in the family context.

The potential of unexpressed healthy virtuality shifts the focus of therapeutic intervention from the care of individual and family deficits to the stimulation of healthy resources through the reproduction of a natural growth context.

1.3. Therapeutic Process

The broad notion of the therapeutic process includes the idea of how a person and his or her family become ill and the path they must follow in order to be cured.

> *Mental illness is a disruption in the growth and development of the personality, involving biological, psychological and social factors. The therapeutic process is a clinical concept by which we refer to the set of transformations that the person and their family can experience through psychotherapeutic treatment.*

The idea of process refers to the succession of psychic changes that are presented as varied realisations, with an internal coherence and a progressive sense towards a human condition that we try to formulate as personality maturation, emotional balance, etc.

Changes that are objectified in concrete realisations, such as interpersonal relationships and subjective experiences that transform the inner world and lead to structural changes in the personality.

This succession is neither linear nor has a single causality, but are moments of destruturing and restructuring of the parts of a whole.

The therapeutic process has the aim of re-establishing the process of growth and normal development of the individual, which due to different factors was stopped and distorted in its evolution.

The patient has to go through the stages in his treatment that he was never able to go through in his family life.

The new experiences, enriching and strengthening the ego, will provide the ego with genuine resources through the identificatory processes, which will modify the structure of the personality.

The therapeutic process is necessarily individual and therefore unique for each person, the variety depends on the clinical pictures, how the illness begins and how long it lasts. Family and social circumstances are also factors that influence it.

1.4. Genuine Ego Resources

> *The concept of "Genuine Ego Resources" refers to an essential aspect of mental health: the maturity of the personality. They are the prerequisites for the ego to develop its own functions (symbolisation, representation, language, sense of reality, impulse control, etc.) and to achieve its goals.*

The lack of Ego resources or the notion of structural deficit allows us to understand an important dimension of pathogenesis and the main goal of the therapeutic process would be the new genuine Ego resources completion.

The condition of defencelessness and helplessness with which we are born, could be defined as a condition of scarce Ego resources.

The psychobiological development of the personality is, among other things, the acquisition of Ego resources.

In its biological aspect, the constitution and maturation of the nervous system play an important role, but where the fundamental part is played is in the psychological-relational aspect, where life experiences will determine the development of oneself, through the identificatory processes.

Some of these experiences lead to a positive structuring of the Ego and others will hinder its development, producing alterations of the Ego that will give rise to different pathologies.

From a therapeutic perspective, such patients are beyond the area of conflict and require a different treatment, where healthy emotional experiences will allow the incorporation of new resources of the Ego, which are indispensable for personality's restructuring.

1.5. Identification Processes

As several psychoanalytic authors have shown, "identification" is one of the fundamental processes in the structuring of personality.

> *The "identification processes" intervenes from the first moments of life, especially in the early relationship of the child with its caregiver, constituting, as S. Freud argued, the most primitive form of affective attachment, and producing long-lasting modifications in the individual.*

The identification represents a set of operations that determine the complex task of the constitution and organisation of the "self".

These processes are intertwined with R.I., and their quality is determined by the emotional climate and ego resources of the parents.

J. García Badaracco differentiates these processes on the basis of their qualities, into normogenic and pathogenic.

These processes take place in the intimacy of the R.I. and that the emotional climate and the parents' own ego resources will determine the quality of these identifications.

In the "structural identifications" (normogenic), mechanisms of assimilation and accommodation are set up between the members of the interdependence through a creative exchange which, over time, allows the development of an intersubjective dimension in a healthy mutual interdependence, which makes it possible to differentiate the self from the "other". In this way, through a process of de-symbiosis, greater individuation and autonomy can be achieved from a primitive symbiosis, while these normogenic identifications become part of the personality structure.

If instead of the process described above, an anomalous development occurs due to a lack of structuring identifications, the individual will be trapped in a pathological reciprocal interdependence, the symbiosis will not be successfully resolved and there will be a lack of ego resources or a structural deficit.

These identifications will incorporate into the psyche elements that remain split off from the structure and that will act as invading presences, which "constrain" the psyche to organise itself in function of these presences. These pathological identifications are organised as split-off parts of the mind, giving rise to what J. García Badaracco called the "maddening object". In these cases we always find a history of traumatic events and psychic suffering. The presence of the other "inhabited" the subject's psyche, preventing him from "being himself" and conditioning his own life.

1.6. Life Experience (Vivencia)

The word "*vivencia*" was introduced into the Spanish language by the Spanish philosopher Ortega y Gasset. Trained in Germany, on his return to Spain, he could not find a word to translate the German term "erlebnis", which differed from the word "erfahrung" (experience).

The latter refers to a practice that gives knowledge or ability (training) to perform a task.

Vivencia represents a special experience that modifies the Ego and "marks" the personality. Ortega y Gasset (1913) describes it, as "everything that reaches the Ego with such immediacy that it becomes part of it, is an life experience". In the field of psychology, an life experience lived with an emotional intensity that leaves a mark on the subject's life.

From our perspective, *vivencia* is a founding experience that occurs in the intimacy of "reciprocal interdependencies" and acts as a framework for the identification processes.

Normally, the calming and protective experiences produced within the family give rise to the "genuine Ego resources" derived from normogenic identifications, essential to carry out a satisfactory growth and development process.

Alongside the reassuring and protective *vivencias*, we find traumatic *vivencias* that are splited, and threatening the incorporation of these “Egoic” resources, distorting the growth and development of the personality, and giving rise to psychic suffering and therefore to mental illness.

J. García Badaracco, in the last years of his life, gave relevance to the theme of *vivencias*, as M.E.Mitre points out in his work "Healing from *vivencias*" (2020); the mind in its origins is essentially “*vivencial*”.

The baby experiences the relationship with its parents in terms of *vivencias*, within "reciprocal interdependencies" and this emotional exchange produces the healthy or unhealthy acquisition of genuine ego resources.

In psychotherapeutic practice, we have observed that intellectual understanding does not modify the emotional charge of the traumatic situations experienced by the patient.

We know that the suffering person needs more than interpretations, as many authors – who opened the possibility of treating "difficult" patients – have pointed out.

The presence of the therapist as a real person creates a real experience that gives the patient what he or she lacked in the infantile stages.

The greater symmetry in treatment encourages emotional proximity between the patient, the family and the members of the therapeutic team, creating an emotional climate that will act as a stimulus for normogenic identifications, necessary for the acquisition of new Ego resources, which will restore the process of growth and development that was interfered with.

1.7. Expanded Mind

The Multifamily Psychoanalysis Group functions as an "Expanded Mind", "a great thinking mind" (J. García Badaracco, 2000).

> *Each participant enriches the whole by contributing his or her point of view; each individual contribution can generate associations in others that enrich the whole. A creative spiral can be created that contributes to the modification of rigid structural patterns (pathogenic interdependencies), which function in people's minds as reverberating circuits that torture and make them ill.*

The ability to think with others allows one to expand the mind without losing autonomy, creating a network of knowledge that has a high therapeutic potential. The climate of security, trust and solidarity encourages one to "think together" what one cannot think alone.

Observing different ways of understanding life in others allows participants to begin to reflect on their own way of understanding life and leads them to discover their own "way of being" in the exchange with others.

2. GENERAL RECOMMENDATIONS FOR CONDUCTING MFPG

2.1. About the Setting

The MFPG offers a natural and flexible environment, which reproduces a broad social gathering, where participation is spontaneous and authentic.

Flexibility is inherent in this group and participation does not require a formal commitment to continuous attendance (depending on whether it is an open or slow-open group). The requirements for the meeting are minimal: place, day and time.

Duration varies from 90 to 120 minutes and usually takes place weekly or fortnightly throughout the year.

> *Teamwork is essential to respond to the complexity of the situations that arise; more than a work option, it is seen as a necessity to promote psychic change.*

The team works at the unconscious level and will have to contain and support in various ways the regressive moments that arise from intense emotional situations, sometimes of great suffering, sometimes of extreme violence and sometimes of intense withdrawal.

The team's activity of containment and support will make it possible to transform the pathological regression, characterised by the ego's lack of resources to deal with internal and external reality, the destructive impulses and the high level of anxiety triggered, into a regression that is useful for the therapeutic process, in which the healthy aspects that have been held back in the growth and development of the personality are recovered.

This is the way of working that characterises the healing philosophy of the MFPGs.

2.2. Multiple Transferences

Most contemporary psychoanalytic writers agree that all psychoanalytic therapies - be they individual, group, couple or family therapies - must fulfil one primary condition: working with the transference. What distinguishes the various methods of analytic work is their understanding and use of the transference.

S. Freud never saw the transference as something generated by psychoanalytic treatment, but rather as something that is uncovered and made visible. Moreover, it is characterised as a general and universal phenomenon, that is, from our point of view, a social phenomenon.

The MFPG, as a sample of a wider social reality (mini-society), allows us to observe how the transference plot involves us all and creates a "psychological field of multifamily structure”.

It is important to note that any formal framework with pre-established rules and norms contributes to the emergence of the transference, but at the same time its analysis partialises and denaturalises it, usually excluding the healthy aspects of psychic functioning that are essential to the therapeutic process.

Experiencing the MFPG as a social setting shows us that this is the natural context in which transference is fully expressed and which allows us to work with it more appropriately, especially with those severe patients who suffer from a structural deficit, those who J. García Badaracco defined as lacking authentic ego resources.

In clinical work, the concept of interdependence clearly shows the significant relationships between the participants, including transference as an expression of the unconscious aspects of the relationships, and interaction as a consequence of the actions of some towards others.

This interaction extends over time and is the essence of pathological interdependence.

In MFPGs, the transfert is "multiple" because all participants, including the Conductors, contribute to structuring a "psychological climate of multifamily structure". At the same time, transference is "dispersed" (Mascaró Masri N., 1990) because projections are made towards the members of the group and the team; in this way, the setting and the institution reduce the emotional load and allow more effective work on the most harmful factors that conceal psychic suffering.

The broad social context provides a greater restraining force that drastically reduces the emotional impact of highly traumatic situations that are reactivated in the therapeutic activity.

2.3. Emotional Climate

It is necessary to emphasise that the variety of phenomena that occur in a MFPG generate a psychological field with a multifamily structure, the complexity of which the Conductors have to account for.

One of the main tasks of the Conductor and the Facilitator is to create an appropriate emotional climate that allows painful experiences to be shared and that acts as a "trigger" for new identifications that will contribute to psychic change.

It is up to the team to create and maintain an appropriate emotional climate based on trust, which fosters security, solidarity and hope.

2.4. Practical Advices

There is no mention of a specific technique, but the emphasis is on the experiential learning that Conductors have to carry out on the basis of their personal experience. This perspective emphasises creativity and refers to an experiential learning that is able to deal with novel and unforeseen situations, and at the same time must be able to focus on the particular, recognising the specificity of each person and encouraging an open and autonomous attitude.

Here are the key recommendations:

- The Conductor and the Facilitator must encourage a shared, open and inclusive conversation. By observing and understanding the dialogues and the transference plot, hypotheses arise about the relationships and their development. Mutual recognition, in the sense of accepting differences, allows "the best of the other" to emerge, a situation generally not experienced before, which gives meaning to identity. Both the speaker and the non-speaker benefit from this exchange.
- The interventions of the Conductor and the Facilitator can be very varied (Zimmerman's interpretive activity) and should help to maintain an appropriate emotional climate that allows the sharing of life experiences and supports the therapeutic processes of the participants.
- Listen with respect, avoid judgement and consider that what the other person says can add to and complete your knowledge.
- -Do not pretend to be right in order to discourage any tendency to argue and avoid isolation.
- Conductors/Facilitators have a responsibility to alleviate the suffering of those involved and to understand that an appropriate emotional climate will bring out traumatic experiences, sometimes for the first time.
- Tolerate the uncertainty and confusion of 'not knowing' and avoid giving reassuring explanations. Let the group construct the appropriate responses.
- Try to make sense of difficult situations as they arise and to play them down in the light of normal processes of growth and development.
- Ability to tolerate and empathise with feelings of vulnerability and helplessness hidden in defence mechanisms.
- Be careful to recover and preserve the experiential, the emotional and the affective, which is the substrate in which pathological interdependencies are produced.
- Respect the time that each person needs for the shared experience to produce psychic change. Each participant must find his or her own "healing" response without the need for suggestions and interpretations. This is a unique and non-transferable experience.
- Conductors/Facilitators should preferably work on what is present, what happens in each encounter and what it awakens in others. Personal stories can be reconstructed during the treatment of pathological and pathogenic interdependencies.
- Conductors/Facilitators do not have to solve problems, but to create conditions that favour the acquisition of new ego resources that allow one to face life more effectively and with less suffering.
- The exchange between the participants must be playful. Everyone, including professionals, must be able to access and learn from the experiential situations created in the group, which will enrich their personal (and professional) heritage. The Conductors/Facilitators "heal" with the patients. In this way, the group grows and acquires a more horizontal and democratic functioning.
- Regarding the intervention of the participants, the modalities may differ: some consider it right to proceed by a show of hands, others prefer a more spontaneous participation. The group Conductor-Facilitator must be aware of this and encourage a fair use of the floor.

2.5. Healing factors

The main therapeutic aim of the MFPGs is to provide genuine ego resources through living together, which will contribute to the restructuring of the personality, making it possible to "break" the networks of pathogenic interdependencies in which the individual is trapped, through the "psychic change" that gives the possibility of a more consistent identity and greater psychic autonomy.

Here are the main healing factors:

- The shift from pessimism about the incurability of mental illness to optimism about the possibility of recovery creates hope, which is the driving force behind treatment and the therapeutic process.
- Treating people who are suffering by seeing their healthy virtuality, makes them feel better understood and function more adequately.
- Moving from a passive attitude (they heal me) to an active attitude (I heal myself), produces in patients and their families a commitment to treatment.
- Sharing traumatic situations that generate intense psychic suffering with the participants of the group by generalising the problems creates relief, empathy and solidarity.
- Shared conversation based on respect (not making value judgements), recognition (accepting differences), responsibility (caring for the suffering) and recreation (learning from others) has a remarkable therapeutic potential.
- The broad context in which the MFPG develops is the best guarantee of security, containment and solidarity, which allows the expression of the true self.
- The sharing of life experiences generates group cohesion, which makes it possible to begin to trust others and to be able to count on them.

3. FINAL CONSIDERATIONS

After many years of working with such groups, it appears that these broad social contexts have a high therapeutic potential.

The emotional climate plays a fundamental role in this situation. The team must create and maintain a climate of trust and security, stimulate participatory communication/dialogue, develop solidarity among the participants and generate hope for a better life.

A life worth living, where the activity is the product of creativity as the expression of the "true self" and not of a compliance with what is imposed. This situation generates the "vitality" necessary for a healthier life.

The particular dynamics of these groups is determined by the presence of at least two generations (parents and sons), which are joined by other family members and relatives.

MFPGs in healthcare institutions become the central activity of the therapeutic framework and contribute to profound changes in the institution itself.

Finally, it should be noted that this resource has a high preventive value and is used in different medical services (internal medicine, oncology, paediatric dermatology), as well as in non-health institutions for conflict resolution (education, companies, judiciary, etc.).

SECOND PART
“THE COMPETENCIES OF THE CONDUCTOR AND FACILITATOR OF THE MULTIFAMILY PSYCHOANALYTIC GROUP”

INTRODUCTION

From the path of shared reflection undertaken over the months of work between the partners to develop the competences matrix of the Conductor and Facilitator of the MFPGs, a "Field" of competences was born. The "Field" is an expression that is well suited to identifying this dynamic, evolving area, which can have specific connotations regardless of the elements that integrate it, as the competences are variously implemented in the contexts that require them.

Precisely, in the case of the competences of the Conductors and Facilitators in the meetings of the Multifamily Psychoanalysis Groups, the Field was marked by 18 families of competences that intertwine to facilitate listening and communication between the participants, and which are implemented depending on the situations that arise.

But to develop and implement them, the professional's wealth of knowledge must not condition his relationship with those present nor their reality with pre-established interpretations, while he is ready to welcome the suggestions and indications that arise from the group without preconceptions.

This openness of thought becomes a sine qua non in any reflection and approach aimed at defining competences, it is a capacity that also includes Freud's indication when he speaks of "suspending the judgment of reality" in the relationship with patients.

At the basis of reflections on competences there are therefore preliminary conditions that ensure that competences can be developed.

Already in the "European Framework of Key Competences" of 2008, the importance of the competence of "Learning to Learn" was strengthened, a message spread since the end of the last century in the training sector but not only, fundamental for the acquisition of other competences and for the development of competencies that are acquired from the first years of life, in formal, informal and non-formal environments and training situations.

“Learning to learn” is the competence at the basis of the individual's autonomy and is fundamental in the management of multifamily psychoanalysis groups, but in this mix of competences of the Conductor the reflection on the need has been inserted, which is also preliminary to the analysis and development of any competence, to also introduce as a premise the ability of the Conductor who intervenes to "Learning to unlearn".

When García Badaracco participated in family groups, he invited his colleagues to take part with "Vamos a aprender".

In this invitation, "Learning to learn" is inextricably associated with "Learning to unlearn", and these two conditions represent the prerequisites for the development of competences and are contained in that "Vamos a aprender" which involves the willingness to put oneself at stake, to learn from the group but also to unlearn and build new knowledge, together with the group.

Both "Learning to learn" and "Learning to unlearn" are well represented by the competencies included in the "Personal, ethical, social and cultural competences" area, competencies linked to

the culture and ethics of the Conductor's behavior and to need to learn to transfer knowledge in different family and/or therapeutic contexts.

The ability to develop new competences that arise from the comparison between individuals and cultures, the ability to adopt ethical and respectful behavior depending on the conditions, and the predisposition to affective learning strongly represent these basic conditions that distinguish the work of the Conductors and the Facilitators of Multifamily Groups, and which are conveyed by that invitation of “Vamos a aprender” by García Badaracco.

1. THE MULTIFAMILY PSYCHOANALYSIS GROUP

The Multifamily Psychoanalysis Group (MFPG) is a therapeutic setting which enables a heterogeneous group of patients with different illnesses and their families to be approached and treated.

Typically, the MFPG consists of 10-50 people, but on rare occasions can reach up to a hundred participants. Made up of families from different backgrounds and socio-economic classes who come together to share a common experience, the MFPG replicates a miniature version of our society, where participants can face challenges and share their fears and anxieties in a safe and trusting environment.

In addition to patients and family members, other professionals take part in the group. Healthcare professionals, in our case Conductors and Facilitators, lead the group and work together as a therapeutic team through co-therapy.

The MFPG usually meets weekly or fortnightly and lasts between ninety and one hundred and twenty minutes. Participation is open to anyone at any time. Although consistency is preferred, occasional absence is not a disadvantage.

1.1. Theoretical Aspects

The MFPG, consisting of several families with at least one psychotic component, provides a unique and universal framework for understanding mental illness and its treatment, and resolves the false dilemma between systemic or cognitive-behavioural therapies, which work on the present, and traditional psychoanalytic treatments, which work on the past.

This method leads to the creation of a new scenario in which patients and members of the various families can confront their hitherto unspeakable experiences and reactivate in real time, in front of a large group, the fundamental interactions between pathogenic and pathological factors that have determined the development of their distress over time.

This allows a process of substantial change in the climate experienced within the pathological family units, from which the patients can benefit by stepping out of the role of the incurable, and the family members by becoming active participants in the treatment.

This allows everyone to remember and understand what happened in the past, without having to take responsibility for it, and to reflect together on how best to contribute to the development of the treatment process today.

The MFPG offers a natural and flexible environment that replicates a broad social gathering where participation is spontaneous and authentic. Flexibility is inherent to the group. Participation does not depend on a formal commitment to continuous attendance and people participate according to their own needs and interests.

The therapeutic team is flexible and consists of a number of experts with similar methodological backgrounds (e.g. Conductor, Facilitator and, in some contexts, Supervisor). At an unconscious level, it should function as a surrogate family, supporting and containing regressive moments resulting from very intense emotional states. These states can manifest themselves in a variety of ways, including severe withdrawal, verbal abuse and severe suffering.

The team's attitude of containment and support makes it possible to transform pathological regression into regression that is useful for the therapeutic process.

The experience of the MFPG as a social field suggests that it is the natural context in which transference can be expressed in its fullness and worked on in the most appropriate way, especially with severe patients who have a structural deficit, i.e. those who Jorge García Badaracco defined as lacking sufficient 'ego resources'.

The concept of interdependence in clinical work, central to García Badaracco's thinking, clearly shows the importance of meaningful relationships between people. It encompasses both transference, which expresses the unconscious aspects of relationships, and interdependence, which refers to the consequences of one's actions on the other and vice versa.

This mutual interaction is maintained over time and is the essence of pathological interdependence.

Looking at the development of psychoanalytic theory and the tools used in relation to treatment effectiveness, we can see how group experiences have emerged from the difficulty of intercepting and bringing to light deep, meaningful and lasting psychic changes in the classic dual therapist-patient condition.

Group settings have enabled the emergence and spread of more successful approaches, such as therapy based on a multifamily approach.

According to JGB1:

"Multifamily sessions create a psychological environment conducive to coexistence, personal reflection, conflict resolution and mutual learning.

In other words, they offer the possibility of resuming regular communication in an authentic human context, activating the underlying forces that bind individuals to their family and social environment and improving their ability to resolve conflicts. These forces are linked to the affective involvement that comes from communicating feelings and words to other family members and to those who, even from different backgrounds, have experienced similar conflict (p.28).

(…) Bringing the patients of my ward together with their families and auxiliary staff, as in a therapeutic community, allowed me to find a way of exercising a leadership which, working systematically from de-idealisation, would make it possible to use the social fabric to promote behavioural change, improvement and healing.

By integrating the psychoanalytic reading of the individual unconscious with the possibility of neutralising the reciprocal influence of the pathogenic factors at work in the interdependencies in which mental illness manifests itself within the family unit, it was possible to recover the healthy group interactions and reconstructive social experiences that can take place in the context of the large group with its traditional connotations, such as those of tribal environments".

(…) "Experience has shown that one of the difficulties to be overcome is the fear of the therapist or group Conductor, who tends to feel much more exposed in a multifamily context than in small group therapy or individual psychoanalysis. But in reality I did not have to face the fear that uncontrollable group forces would be unleashed, a situation that seemed all the more likely the larger the group, but rather the opposite, as if the presence of many people increased the emotional security of each participant" (*p.35*).

[1] García Badaracco J. (2004), "Psicoanalisi Multifamiliare. Gli altri in noi e la scoperta di noi stessi", Bollati Boringhieri, Torino

In this context, the MFPG:

"*…allows us to read the unconscious conveyed in the conversations of the participants, who then and there spontaneously dramatize their conflict.*

If we consider the family as a transitional context for the growth of the individual, the MFPG must tend to facilitate the opening of new mental spaces. This allows the patient to experience a new development through the therapeutic action".

"*…The experience I have had in multifamily groups has made possible, as we will see in this book, countless original developments. Among them, I can point to the possibility of integrating different approaches and theories into a broad virtual unit, encompassing the individual psychoanalytic dimension, the group dynamics and the pathology of the family, so that different approaches and many other therapeutic resources can be used by the participants, to the extent that each is capable, without falling into an impoverishing eclecticism*".

(…) "*It is the multifamily group where all the phenomena described in other contexts can be seen and worked on therapeutically. In some cases this context is the one that offers the best possibilities. In general, we can say that every person can have some kind of valuable experience that can break a deadlock in the therapeutic process taking place in any other context. The multifamily group can revive a stagnation, speed up a stalled process, and offer possibilities for the psychic change necessary for particularly difficult pathologies when the usual techniques fail to produce results. It is a different way of working in so many ways that it is difficult to specify. Instead of questioning the reason for certain changes and the nature of the technique used, it is often better to start from the therapeutic results obtained*" (p.36-37).

Dr Andrea Narracci, one of Italy's leading therapists, promoter of the MFPG experience in Italy and a personal friend of JGB, agrees:[2]:

"*The MFPG is the only place where psychosis manifests itself in its typical way", said Jorge García Badaracco. Neither in individual therapy, nor in group therapy for psychotic patients, nor in nuclear family therapy can we observe the functioning of psychosis as in the MFPGs. We always start from the idea that the study of human behaviour is based on the assumption that the people in front of us are similar to us and, if they are not, that they may be more or less affected by the pathology.*

The study of psychosis is usually approached from a partial and inadequate observational context: in individual therapy, only part of the whole that constitutes madness is considered; in group therapy for psychotic patients, the context is certainly not the natural one, and therefore what happens may only be a reproduction that may resemble reality, but is not reality.

In the therapeutic context of family therapy, the possibility of reflection around a single pathological context is added, but this does not allow the confrontation of experiences and 'possible' psychoses. In family therapy, the pathological tension hinders the attempt to create a shared climate of self-observation and thus a therapeutic process. In all these approaches, however, we start from the possibility of experimentally observing the family 'syncytium' at work, i.e. a couple or a trio of persons without defined boundaries who form a whole and are confronted separately with other family 'syncytium's or with members of other families. We can feel and understand that the normal state of life of schizophrenics and their family members is different

[2] Narracci A. (2011), "Il nuovo contesto di cura per i pazienti psichiatrici gravi in García Badaracco, J. See also Narracci A., "La Psicanalisi Multifamiliare in Italia", Antigone Edizioni, Torino

from ours by observing the enormously greater intensity with which the phenomenon of 'others in us' ('los otros en nosotros'), i.e. the projections and projective identifications that occur in the context of family therapy, manifests itself. Only in the MFPG does the therapist have the possibility of experiencing reality not only from his or her usual point of view, with boundaries, but also from the point of view of others, without boundaries" (p.27-28).

In this sense, the MFPG is a place to observe real dynamics. It is a place for learning, but also, as we shall see, for unlearning.

This approach has significant implications for the competences of MFPG Conductors, which is the focus of our analysis. In the MFPG context, these competences are articulated with the appropriate professional, personal and therapeutic behaviour. However, the Conductors must be aware of their genesis, their dynamics and their effects, which go beyond the unrepeatable *Gestalt* that places them in front of the MFPG participants at a specific and unrepeatable moment.

To explain this, let us use a metaphor dear to photographers, that of the alignment of heart, eye and brain, which Cartier-Bresson conceived as a fundamental characteristic of a good picture. In a similar way, the MFPG is about encouraging the occurrence, analysis and understanding of moments when heart, mind and brain are perfectly aligned.

In the case of the Multi-Family Group it is a matter of taking a snapshot in which the heart, mind and brain are perfectly aligned now, at the moment of the shot.

When these moments occur, a learning opportunity is created for the participants through the experience of a possible transformation towards the direction that the photograph has captured, allowing a glimpse of a reality that did not exist before.

This experience (as the photographer says, a new way of seeing oneself, a unique and unforeseen snapshot) can then be used as a stimulus that releases energy for change, so that one can embark on a journey to become aware of the existence of a self (the 'possible' reality of the snapshot) that is present, alive and capable of generating therapeutic transformation in the MFPG context.

The possible confusion caused by the perception of an active self, which may border on non-self-awareness, is related to the surprise caused by the perception of a living self.

Obviously, in situations of this kind, it is of the utmost importance to know what competences the Conductors should use.

As Antonio Maone argues[3]:

"It is not just a matter of interpreting what is happening, but of actively intervening in the paralysing framework, disarticulating the pathogenic interdependencies and providing the therapeutic resources that activate the self-organising mechanisms that enable the human being to act. (...) [Patients] discover that these processes of de-identification, experienced as profound depersonalisation, are not destructive. (...) [Patients] discover that these processes of de-identification, experienced as profound depersonalisation, are not only not destructive, but are the ones that allow them to get in touch with their 'true self'. They begin to perceive that there is someone inside them, the 'true self', who can have a new opportunity to exploit the virtual potentialities that have been blocked during their development: we can speak of a true rebirth".

[3] In Narracci A (a cura di) (2015) "Psicanalisi Familiare come esperanto", 2015, Antigone Edizioni, Torino

As in a village, the group allows participants to reflect not only on themselves and their own family context, but also on the functioning of several family units similar to their own.

In this way the group provides creative resources to begin to stop endlessly repeating the same mistakes and to disarticulate the pathological interdependencies that block personal growth processes in specific family contexts.

It is here that the difference between multifamily groups and individual or family therapy becomes apparent. In the latter, the focus is on the individual or family unit, and the aim is to explore and resolve the internal dynamics and problems specific to that family. In this context, therapists work primarily with members of a single family, seeking to identify dysfunctional patterns of interaction and to promote changes in family functioning.

In an MFPG, unconscious processes that are partly responsible for suffering emerge spontaneously and can be analysed, processed, understood and possibly transformed. The group values moments of encounter which can become moments of multiple empathic adaptation. More than any other psychoanalytic context, the multifamily group offers the possibility of observing both normal and pathological aspects of the communication, verbal or non-verbal, logical or primitive, that permeates the life of all human beings.

Multifamily group psychoanalysis, working with a group composed of several families and professionals, opens up new perspectives in the treatment of psychosis and presents some significant differences with respect to classical individual or family therapies:

- **The involvement of several families**: the MFPG involves several families, each with their own dynamics and problems; this provides an opportunity to expose different experiences and models of family functioning, paving the way for greater mutual understanding and learning.
- **Shared reflection and learning**: in the MFPG, members of different families can reflect and learn together. This process of sharing and comparing allows them to gain new perspectives and broaden their awareness of the internal dynamics of each family.
- **Avoiding mistakes**: the opportunity to observe the dynamics and mistakes of other families allows each participant to learn from the experiences of others in order to avoid repeating the same dysfunctional patterns.
- **Working on pathological interdependencies**: the MFPG facilitates the emergence, observation and understanding of dysfunctional interdependencies in members of different families. Awareness of this enables therapists to work on understanding and modifying these pathological dynamics and to promote healthier growth for those involved.
- **Strengthening the growth process**: the MFPG provides a context in which families can face challenges together and support each other. This helps to improve and strengthen the individual and family growth process.

The MFPG has other distinctive features:

- People who suffer feel better understood and their behaviour improves when their healthy virtuality is imagined and taken into account.
- The shift from a passive attitude (“they heal me”) to an active one (“I heal myself”) creates a direct involvement and commitment to treatment in patients and their families;
- Sharing traumatic situations that cause intense psychological distress with group participants universalises problems and creates relief, empathy and solidarity.

- Shared conversation based on respect (absence of judgement), recognition (acceptance of differences), responsibility (caring for those who suffer) and reflection (learning from others) has strong therapeutic potential.
- The large group context of the MFPG is the best guarantee of security, containment and solidarity, and allows the 'true self' to express itself.
- Sharing life experiences creates a sense of solidarity and group cohesion that allows people to begin to trust and rely on others.

In summary, MFPG is an evolution of traditional family therapy that greatly enhances the collaborative competences of professionals, patients and their families. The MFPG offers a comprehensive and inclusive approach that promotes confrontation, mutual learning and the potential overcoming of pathogenic interdependencies that impede the capacity for growth and healing, particularly in the context of psychosis.

1.2. Competences of the Conductor: importance and criticality

MFPG's methodology can be an effective treatment option. However, in some situations it may also present some potential risks and challenges that need to be considered:

- **Transference, counter-transference and unconscious mental processes in the group**: Conductors need to be aware of transference and counter-transference, both of which are more complex and visible than in individual psychotherapy. Conductors need to pay close attention to transferential phenomena directed towards themselves, other team members and participants.
- **Conflicts and complex dynamics**: because there are several families in the group, conflicts and complex dynamics may arise between group members. In order to prevent disputes from escalating and hindering the therapeutic process, the Conductor must be able to deal with these circumstances productively.
- **Confidentiality and privacy**: sharing information between multiple families can compromise their confidentiality and privacy. Conductors need to provide a safe and secure environment. They need to encourage confidentiality and set clear rules for sharing information within the group.
- **Limitations of generalisation**: although it may be useful to compare different families in order to learn from different experiences, it is important to remember that each family is unique and the dynamics may vary considerably. Therefore, models or approaches used with some families may not be appropriate or effective for others.
- **Uneven involvement of families**: some families may participate actively and benefit fully from the group, others may be more passive or find it difficult to take advantage of the group dynamic. The Conductor must be aware of this heterogeneity and try to involve all families equally and effectively.
- **Emergency management**: psychosis can be a complex illness and sometimes emergencies or crises can occur within the group. Conductors need to be prepared to deal with these situations appropriately. They need to have a support network and resources available to deal with any crisis.
- **Dependence on the group**: in some cases, family members may become too dependent on the group or the Conductor and find it difficult to apply the learning outside the group context. The Facilitator needs to encourage family empowerment and autonomy to promote sustainable change.

- **Negative effects of confrontation**: confrontation with other families can be helpful, but it can also cause tension or insecurity in participants. MFPG Conductors will carefully balance the level of confrontation and only engage in confrontation when it is constructive for the therapeutic process.
- **Exposure to traumatic content**: group participants may be exposed to potentially traumatic content, such as stories of violence, abuse or death. This can be particularly difficult for group members who have already had traumatic experiences. Conductors need to know how to handle these situations and maintain the stability of the group without hiding the truth.
- **Comparison with others**: group members may feel compared with others, especially if they have more severe symptoms or do not improve at the same rate as others. This can lead to feelings of shame, inadequacy and isolation, which the Conductor must try to mitigate and manage while encouraging empowerment and autonomy.
- **Affective bonds with other group members**: group members may develop bonds with other group members that make it difficult for them to leave the group. This can be particularly difficult if group members have had a positive experience in the group. Conductors need to encourage autonomy and healthy management of the affective bonds created within the group.

In summary, MFPG is a therapeutic modality that has high curative potential but also presents challenges and difficulties that can be very complex. To ensure that each participant receives safe and effective treatment, it is essential that any risks or barriers are identified and carefully managed. The background and training of the Conductors are essential to reduce these risks and ensure the effectiveness of the therapeutic group.

1.3. Competences of the Conductor: a first list

The MFPG Conductor must have a different set of competences from those of the family therapist, the group therapist and the individual psychoanalyst. In fact, the Conductor is required to have the competences of all three professionals and to integrate them in different and creative ways, without having to follow a rigidly established plan.

The competences shared with other therapists are:

- **Psychoanalytic expertise**: psychoanalytic training differs from the others in that the future psychoanalyst also experiences the patient's point of view through personal analysis.
- **Clinical competences**: the Conductor must have specific clinical training with an emphasis on family and couple therapy.
- **Group competences**: the Conductor must have a good knowledge of group psychology and the dynamics generated within a group.
- **Leadership competences**: the Conductor must be able to lead and manage the group effectively.
- **Relational competences**: the Conductor must be able to build trusting and supportive relationships with group members.
- **Communication competences**: the Conductor must be able to communicate clearly and concisely, both with group members and with other professionals involved in the treatment.

The Conductors play a key role in the MFPG. They are responsible for creating a safe and protective environment in which group members can freely express their feelings and share their experiences. They must also help group members understand the relationship dynamics in which they are involved, develop new coping strategies and improve communication. Conductors also need to establish rules of conduct which, as we shall see, tend to correspond to specific areas of competence.

Among the most important are:

- Listen with respect, avoiding value judgements and considering that what others say can be an enrichment to our knowledge.
- Do not pretend to be right. Discourage the tendency to argue in order to prevail over the other without listening, which confronts and isolates us.
- Take responsibility for alleviating the suffering caused by traumatic experiences.
- Tolerate the uncertainty and confusion of 'not knowing' and avoid offering reassuring explanations. It is the group itself that will provide the answers.
- Try to keep normal growth and development as a reference point and not to exaggerate negative circumstances.
- Be able to connect and tolerate feelings of helplessness and defeat behind defences and actions.
- Try to bring out the experiential, the emotional and the affective, which is the substrate in which pathological interdependencies are produced.
- Respect everyone's time so that the shared experience brings about psychic change. Each participant should find their own 'healing' response. There is no need for suggestions or interpretations, it is a unique and non-transferable experience.
- Focus on the present, what emerges in each encounter and what it evokes in others. In dealing with pathological and pathogenic interdependencies, the reconstruction of personal histories is not done to solve problems, but to create the conditions for the acquisition of new ego resources to face life more effectively and with less suffering.
- Ensure open communication so that everyone, including the professionals, can learn and understand from the experiential situations created in the group. This will enrich everyone's professional and personal legacy.
- Advocate that healing is also about the 'healing' of professionals, so that the group grows and acquires a more horizontal and democratic functioning.

1.4 Conclusions

It is clear that MFPG Conductors must have competences that are largely common to other types of therapists.

What makes them 'unique and specific' is their use in the moment, so that some competences, which are part of the cultural background and knowledge of the Conductor, become more relevant than others.

Given the specific structure of the therapeutic environment, the desirable basic and specialised training of the MFPG Conductor can interact both with that of professional figures in the same line of work (Conductor, Facilitator, Supervisor) and with that of figures outside the psychotherapeutic field, strictly understood, but with recognised technical-relational experience acquired in constant daily practice.

In this case, we are not only referring to the theoretical reference background mentioned above, but also to the possession of transversal competences that are part of the personal background and that can be effectively used once they are made transparent and triggered by the subject who possesses and puts them into practice.

This does not contradict the work presented, which formalises a specific technical matrix of Conductor competencies. However, the study considers how there are examples where the accreditation process could be different.

In this way, there is also a “democratization” of participation and knowledge which, if it respects the implicit and explicit "rules" of therapeutic treatment, makes all experiences relevant.

This does not mean that everyone can do the same things or have the same tasks.

As we shall see, more or less all the professionals involved must be able to do the same things, albeit at different levels of responsibility (redundancy of competences and shared knowledge), and must create a common space where there is no need for self-assignment and/or hierarchisation of roles and functions, but only for sharing experiences, without sending contradictory signals and generating dysfunctional positional conflicts.

Indeed, their inclusion and/or empowerment in multifamily groups is one of the most fascinating aspects of reflection on the Conductor's profession and the characteristics of the therapeutic setting.

Finally, the work presented here aims to systematise and codify certain aspects of the Conductor and Facilitator's professional experience in order to make them readable, transparent and transferable.

2. THE MFPG CONDUCTOR'S COMPETENCE SYSTEM: FROM COMPETENCE FAMILIES TO CONSISTENT BEHAVIOR

Before moving from identifying the 18 main families of competences to describing the Matrix of Competences, let's describe the concept of Competence.

This description will certainly facilitate the task of developing the characteristic behaviors of each family and clarifying the links between the two concepts.

2.1. What we can say about Competence

Over the last two decades, the concept of competence has gained strategic relevance in education, training and lifelong learning policies, as well as in the development of human capital strategies in enterprises and, more generally, in public and private professions.

It can be defined as the conceptual (and operational) dimension of analysis around which the following aspects are most developed:

- The learning/teaching processes that take place in schools at all levels, in vocational and higher education and in continuous training.
- The processes for defining and enriching the human capital of individual companies, which are essential for recruiting and employing staff.
- The pathways for the introduction of emerging and non-codified professions (our case), based on the observation of the most effective behaviours, mainly experiential, as they manifest themselves in professional practice.

It is also worth highlighting the impulses for a general reflection on competence that come from the European regulatory context. We refer here to:

- the Recommendation of the European Parliament and of the Council of 23 April 2008 on the establishment of the European Qualifications Framework for lifelong learning, which defines both competences, described in terms of autonomy and responsibility, and their links with knowledge and competencies in order to complete their correct contextualisation.
- The Recommendation A New Competencies Agenda for Europe, COM (2016) 381;
- The Council Recommendation of 22 May 2018 on a new definition of key competences for lifelong learning - COM 2018/C 189/01.
- The discussion paper on managing globalisation - COM (2017) 240.
- A competencies agenda for Europe for sustainable competitiveness, social equality, and resilience 2020 - COM(2020) 274 final.

In our view, the unifying elements of the competence debate are the following dimensions:

- **Observability**: competence exists when someone can recognise it. It is therefore an 'observable' behaviour that can only be recognised in a social relationship.
- **Modularity**: competence is modular, i.e. it can be combined with other competences to produce complex outcomes (families) that are useful for acting in specific challenging contexts. This is the method we have chosen to combine more than a single competence into sets of behaviours (competences) that can be grouped under the same family.
- **Autonomy**: competence is essential to support the managerial dimension of individuals in a context where action and/or change is required.

In other words, competence can be defined as:

“recognisable organisational behaviour in which tacit and explicit knowledge, skills and techniques converge, which the individual uses to perform more or less complex tasks and activities in a given context”.

Understood in this way, the function of competence is not so much to identify the knowledge, skills and/or competences possessed by the individual, but to indicate their actual recognisability in a given context.

This recognisability has a high social and relational value, because only those who do not possess the competence can highlight its real existence when they see it expressed in specific and effective individual organisational behaviour.

We can therefore say that competence has a highly subjective, dynamic and relational nature.

Competence refers to the ability of each person/professional - in this case the MFPG Conductors - to "mobilise" their resources to perform certain tasks in relation to the context, dynamically combining knowledge (general and technical knowledge) and competencies.

Understood in this way, competence facilitates and enables us to act more accurately in the forecasting exercise we are engaged in.

Firstly, it does not enclose the analytical work in a pre-established scheme, but leaves it open, presenting it as a way of observing what happens in the concrete therapeutic experience.

Secondly, because of its highly contextualised and essentially individualised characterisation, it is competence rather than individual professional skill that helps us to identify with sufficient precision the organisational behaviour to be observed in order to verify its effects over time.

The process of describing the observable behaviour in each competence family is based on an intermediate step. This leads to a precise and specific definition of each competence family.

These are defined as organisational behaviours in which the person is able to act with (recognisable) mastery in any work/professional context and are summarised in the expression 'know how'.

The families of competencies selected form the basis for describing the behaviours that characterize them individually.

2.2. Area of Strategic Competences

In this section we define the competences that the Conductor must possess as a basic professional technical background, both theoretical and practical, necessary to understand family dynamics and the interconnection of family members within the family system.

1. ***To be able to consistently adhere to Psychoanalytic Thinking****: to recognise the centrality of the concepts of psychosis and pathological identification in structuring the pathogenic interdependencies updated in the MFPG, in order to link what happens in the individual mind to what happens in the relationship between the individual and the parental figures.*

The MFPG Conductor knows and maintains the validity of these contents and consistently re-contextualises their use in a large multigenerational group situation, facilitating the emergence of the inner world/relational dimension articulation and encouraging its recognition and understanding.

2. **To be able to promote a Systemic Thinking:** *understanding how individual actions and behaviours affect the whole family and how the family system affects individual behaviour, thus promoting change as a systemic process.*

The MFPG Conductor recognises that change within the family system can be challenging and requires a systemic approach. If the family dynamics remain unchanged, addressing individual problems in isolation may not lead to lasting change.

3. ***To be able to focus on a Multi-Generational Approach in a Group:*** *because multifamily therapy involves multiple generations, therapists can work with issues and dynamics that have been transmitted over time. This can provide valuable insights into intergenerational patterns and their impact on family functioning.*

In multifamily group therapy, the multigenerational approach is a valuable aspect of the therapeutic process. In MFPGs, therapists have the opportunity to analyse this aspect in order to understand how the difficulties presented by the individual (designated patient) today have their origins in problems experienced but never addressed in previous generations.

4. ***To be able to use an approach based on Sharing (all kinds of) Emotions that arise in the group:*** *all types of emotions that emerge in the group are important, and therefore the Conductor must correctly address the potential of the MFPGs to contain and process the expression of each emotion, regardless of how it manifests itself.*

This competence is crucial because it is often the overly intense manifestation of different emotions that makes intervention impossible in different therapeutic contexts. MFPG Conductors know how to create a safe emotional context in which intense emotional states associated with suffering can be welcomed rather than avoided, thus supporting their most appropriate and sustainable expression. By legitimising and sharing different emotional states (including their own), they can enable the emergence of past painful experiences and support their processing.

Let us now make some general reflections to support the definition of the competences included in this area, which will help us to place the area of strategic competences in a precise theoretical framework.

The originality of JGB's work lies in the fact that he has brought together different points of view belonging to different conceptual worlds, something that was very difficult to imagine at the end of the 1960s. Interested in understanding the human soul and behaviour, he completed his medical studies in Argentina and lived for eight years in France, where he deepened his knowledge of psychiatry, neurology and psychoanalysis.

On his return to Buenos Aires, he won a public competition and became head of one of the inpatient wards at the BA Men's Psychiatric Hospital, where he began to learn about serious patients and the way they were treated. His first impression was that they were not being treated as human beings, and he began to do so, to the disapproval of the other ward managers. The patients got the message and their condition began to improve.

At this point, JGB decided to meet with the patients' families to discuss the possibility of some patients going home. The group, which included patients, family members and carers, began to meet regularly. As JGB said: "There were three actors who helped me make sense of what I was seeing: the patients, the parents, and psychoanalytic thought".

a) A first clear element emerged: the patients were not different from one or both parents, as they claimed. This led him to believe that in every psychotic family there was a symbiotic relationship between a child and a parent.

The problem was not the schizophrenic patient - 70 per cent of those admitted to the ward had been diagnosed as such - but the relationship between the patients and the person who had cared for them most up to that point in their lives.

JGB's quest for understanding led him to use:

1. psychoanalytic thinking, with reference to the concept of symbiosis;
2. in the context of psychoanalytic thinking, shift the focus from what is happening within the individual to what is happening between the individual and the person who has always cared for him/her, and thus to the relationship between the two;
3. systemic thinking, one must interpret pathological situations within their context. In 1956, the work of Gregory Bateson and others established a new epistemological order. This

order recognised that the behaviour of schizophrenic patients was linked to their context and that it was possible to attribute meaning to it.

b) JGB and his colleagues were struck by the finding that patients felt better when hospitalized in the reorganized therapeutic community ward than when at home with their families. It was confirmed that the issues were linked to the patients' treatment. While hospitalized, each patient was treated as an individual, resulting in an improvement in their condition. However, upon returning home and being surrounded by the same relationships that had contributed to their illness, their condition rapidly declined.

It became evident that issues arose within significant relationships, often with one in particular, and that therapeutic work needed to involve questioning how both members experienced that relationship.

Simultaneously, it appeared that a group of several families, including at least one member from each patient's family, provided the best context for discussing these issues.

(Competences 1 and 2 define the mixed dimension of the intervention)

MFPGs enable framing of problems in intergenerational terms.

The approach does not involve reconstructing the original relationship through transference or focusing solely on one severely pathological family at a time. Instead, it involves creating a large group that includes patients and families (at least one member per family) as well as various professionals.

The task of reconstructing the family history of the people currently involved is made easier by the presence of several families, complete or partial, rather than just one at a time. This helps everyone to realise that they are part of a family both in space (the current one) and in time (the set of relations between blood relatives from which each of those present comes).

Participants can gain an understanding that present family problems, expressed through the suffering and behaviour of a designated patient, may have originated from the relationships between one or both parents and their parents, including the patient's grandparents, or even earlier.

(Competence 3)

The process of understanding their own condition can be very painful and difficult for all participants in MFPGs. However, they feel that they are in a place where their suffering is acknowledged and welcomed, which motivates them to engage in the work that can be done together.

The shared suffering of all those involved, including patients, parents, other family members and professionals, becomes the glue that allows them to feel less alone and work together to overcome their situation.

The shared suffering of all those involved leads them to form an alliance. Anyone can regain the confidence and strength to contribute to improving the well-being of patients, families, and professionals.

(Competence 4)

2.3. Transversal Therapeutic Management Competences Area

These are the core competences specific to the profession, and their possession is fundamental to the performance of the role of Conductor.

The competences in this area are:

> 5. ***To be able to use excellent Communication Competencies****: effective communication is crucial in MFPG. Therapists should be able to listen actively, show empathy and facilitate open and honest communication between family members.*

Communication competencies are essential for therapists in MFPGs. Effective communication lays the foundation for building trust, understanding family dynamics and facilitating positive change within the family system.

> 6. ***To be able to work for the re-Discussion of Conflicts****: families in MFPGs may experience conflict and tension. Therapists should be able to help families manage and resolve conflicts constructively.*

At the same time, when families come together in groups, conflicts and tensions may arise due to different perspectives, needs and communication styles. Conflict resolution competencies enable therapists to help families deal constructively with these challenges.

> 7. ***To be able to use a non-intrusive group conduction and maintain a Supportive and Empathic Climate****: the MFPG Conductor must create and maintain an atmosphere of support and empathy. It is necessary to create a psychologically safe environment in which no one takes the place of another and everyone feels protected and understood in their spontaneous self-expression.*

In calibrating the emotional climate of MFPGs, non-verbal messages carry more weight than verbal content, so it is essential to pay attention to 'how it is said' as well as 'what is said', and to ensure consistency between the two levels. It is crucial to ensure parity of exchange through mutual empathic listening.

8. ***To be able to take advantage of Groups Relational Dynamics, being aware of multi-transferences and enactments****: the MFPG Conductor must be able to use Group Relational Dynamics and be aware of 'metaphorical mirroring', 'multiple transference' and 'enactments' as they occur in the MFPG.*

In the multifamily context, the phenomena present in the bi-personal dimension take on a "multiple" form; the Conductor must therefore be able to use them as an enrichment of the therapeutic field of action, assigning the function of "third mediator" to the group dimension. The Conductor should be able to develop the collective Capacity to discover the transference dimension in every interpersonal relationship, so that all participants can first recognise and see in the other something that also concerns them. All participants can help to bring out these phenomena and make them manageable in this new healing context.

9. **To be able to work with Flexibility and Adaptability**: *adaptability and flexibility in therapeutic approaches are essential to address different issues effectively*.

Families participating in multifamily group therapy may come from different backgrounds and present a wide range of needs and challenges. Adaptability and flexibility in therapeutic approaches allow therapists to tailor interventions and strategies to effectively meet the unique needs of each family.

10. ***To be able to enhance Facilitations****: the MFPG Conductor needs to create a safe and supportive group environment for more families to interact and engage in therapy together.*

This requires strong facilitation competencies to manage group dynamics, encourage participation and ensure that all voices are heard.

11. ***To be able to promote Resilience****: by using the characteristics of the multifamily context in creative ways, MFPG therapists can empower participants to develop new competencies by approaching problems with a flexible attitude and experimenting with coping strategies in a collaborative way.*

This approach provides adaptive support towards an increased Capacity to cope with tense and stressful situations, increasing the potential for positive change.

12**.** ***Capacity to use Therapy Open Format****: in general, multifamily therapy sessions have an open format that allows different families or family members to come together in a group context according to their needs and/or abilities.*

Each family or family member may have specific requests for help or concerns that can be addressed in the context of the larger group. This requires the Conductor to be able to meet and work with multiple individual and family needs simultaneously. This format offers the advantage of a flexible, non-constraining context that can be adapted to different needs; it also helps to tolerate uncertainty and turn unpredictability into creative surprise.

13. ***To be able to encourage a Collaborative Exploration****: MFPG therapists actively encourage participants to engage in collaborative discussions to explore personal issues and concerns and to learn from each other's experiences.*

This collaborative approach creates a rich and varied therapeutic environment.

14. ***To be able to promote Shared Learning****: MFPG Conductors enable participants to benefit from shared learning by observing and engaging with other families facing similar or different challenges, thus facilitating the active empowerment of each individual in the healing process.*

This experience promotes a sense of universality, reduces feelings of isolation or stigma, and contributes to a supportive and enriching therapeutic environment.

The set of transversal management competences forms the core of the activities that a leader and Facilitator should be able to carry out in order to promote the creation and growth of an MFPG.

On the one hand, the Capacity to make use of these competencies is a measure of the quality of the work of psychiatrists and psychologists, who, starting from a basis of more in-depth studies - psychoanalytic, systemic and group theory - are led to revisit them in a creative form in order to become true "Conductors" of an MFPG. On the other hand, it also measures the quality of the work of social workers, nurses and psychiatric rehabilitation therapists who, accustomed to a systematic encounter between theory and practice in the performance of their specific professional function, can make an original contribution to the implementation of MFPGs in the role of 'Facilitators'.

The initial hypothesis of this Erasmus project was based on the following considerations:

- in the MFPG, the pathology that afflicts patients can be traced back, in terms of its origin and its persistence and tendency to worsen (chronicity), to a failure to recognise the importance of traumatic events and/or unresolved grief in the evolutionary history of relationships between members of different generations of the same family.
- The Capacity to conduct-facilitate an MFPG is both practical and theoretical knowledge aimed at making the experience of freeing oneself from self-mutilating effects on important parts of the self accessible to those involved in these complex mechanisms affecting family members of different generations.
- The experience of MFPGs has shown that the theoretical knowledge of 'Conductors' and the practical knowledge of 'Facilitators' can co-exist; indeed, ideally, they should be combined. There are Conductors who can be too theoretical, and Facilitators who tend to be too practical. It would be good if both aspects were present in each 'Conductor' and each 'Facilitator', albeit in different proportions. The articulation of differences is always a factor for personal growth.
- At the end of the day, it is the result that counts, and the aim is to become "experts in recognising the importance of emotions" in terms of understanding and reconstructing the history of psychological-psychiatric suffering that anyone can face in their life, in a minor or major form.

2.4. Personal, Ethical, Social and Cultural Competences

Competences belonging to this area are those related to the culture and ethics of the Conductor's behaviour and those related to the need to learn how to transfer knowledge in different family and/or therapeutic contexts.

The competences belonging to this area are:

15. ***To be able to conduct Assessment and Diagnosis****: competence in conducting family assessments and diagnosing family problems is important in understanding the needs of the families involved, developing appropriate treatment plans, and empowering them to take an active role in their own healing and growth.*

16. ***To be able to improve the own Cultural Competence*** *in order to provide inclusive and effective therapy, it is essential to be sensitive to and understand the cultural background of the families involved in MFPGs*.

This is essential to foster an inclusive climate that turns multiple differences into resources and to enrich the multifamily dimension through multiculturalism and multiracialism.

17. ***To be able to maintain Ethics and Boundaries****: in order to properly utilise the dimensions of openness, inclusion and integration in this specific setting, ethics and boundary setting are of particular importance in MFPGs*.

Maintaining ethical standards and setting clear boundaries is essential to ensure the safety, respect and well-being of families and to guarantee the integrity and effectiveness of the therapeutic process.

18. ***To be able to be open for affective*** *learning (through participation in MFPGs, training, supervision and Ateneo, therapy): MFPG 'Conductors' must always be ready to learn something new about their own emotionality, to promote the affective dimension of change and to use their 'vivencias' creatively*.

Through their affective learning processes, MFPG Conductors foster the development of new attitudes in the transformative experience of each participant; the Capacity to activate affective learning in the group allows new emotional competences and relational competencies to emerge.

Finally, it is necessary in the area of social, cultural and ethical competences:

- not to be satisfied with the guidelines of psychiatric analysis alone, and therefore, while it is necessary to know the psychopathology, it is equally important not to stop there;
- to pay close attention to the "socio-cultural" dimension of the circumstances in which the facts to be dealt with occur, since we know that they are influenced by the context in which they occur;
- to base actions on mutual respect.

It may seem obvious, but it is not: the encounter with the other is often 'disturbing', unforeseen, it challenges us, it forces us to ask questions. If we are ready to ask them, we can be mutually enriched, otherwise it is better to avoid or limit contact. In order to understand and help others, it is necessary to learn to suffer with them.

3. MATRIX OF COMPETENCIES' FAMILIES

1. To be able to consistently adhere to Psychoanalytic Thinking	**Strategic Knowledge Area**
2. To be able to promote a Systemic Thinking	
3. To be able to focus on a Multi-Generational Approach in a Group	
4. To be able to use an approach based on Sharing (all kinds of) Emotions that arise in the group	
5. To be able to use excellent Communication Competencies	**Area of Transversal Therapeutic Managerial Competencies**
6. To be able to work for the re-Discussion of Conflicts	
7. To be able to use a non-intrusive group conduction and maintain a Supportive and Empathic Climate	
8. To be able to take advantage of Groups Relational Dynamics, being aware of multi-transferences and enactments	
9. To be able to work with Flexibility and Adaptability	
10.To be able to enhance Facilitations	
11.To be able to promote Resilience	
12.To be able to use Therapy Open Format	
13. To be able to encourage a Collaborative Exploration	
14. To be able to promote Shared Learning	
15. To be able to conduct Assessment and Diagnosis	**Area of personal, ethical, social and cultural competences**
16.To be able to improve his/her own Cultural Competence	
17. To be able to maintain Ethics and Boundaries	
18. To be able to be open for affective learning (through training, supervision and Ateneo, own therapy…)	

PART THREE
"TRAINING PROGRAM FOR THE CONDUCTORS AND FACILITATORS OF THE GROUP OF MULTIFAMILY PSYCHOANALYSIS

INTRODUCTION

In the complexity of the results emerged from the field research carried out by the partners as the first step of the project "FA.M.HE." , here it seems useful to emphasize how it has been possible to highlight an increasing diffusion of the multifamily experience in the prevention and treatment of the different forms of psychological diseases that, however, is still limited by different forms of resistance institutional, cultural and ideological, which must be taken into account by investing in appropriate training aimed at the culture and functioning of care and mental health support contexts.

In fact, one aspect considered very important by the participants in the research, family and technical of different theoretical orientation, is the training of the Conductors and Facilitators, stressing that the development of their competencies should be based on sound theoretical and technical training but that includes an experiential clinical component.

In particular, with regard to MFGPs, different ways of working emerged from the research, which highlight the need for a structured shared training on the individual competencies of the Conductor and the Facilitator, on the support to the technical team and the preparation of the socio-cultural context in which the MFPG are carried out.

The data that emerged converge on the urgent need to create a specific and solid training for MFGs conductors. This meets another of the objectives of this project: strengthen the role and role of the MFG Facilitator/Conductor in the Labour Market and Mental Health Services through a European training curriculum based on knowledge of key PMF concepts and the acquisition of essential competencies and competences.

1. LIPSIM'S TRAINING EXPERIENCES

1.1. The journey so far

Since 2016, the Italian Laboratory of Multifamily Psychoanalysis (LIPsiM) has been providing training activities for psychotherapists interested in deepening their knowledge of the multifamily methodology, which has been gaining popularity in Italy in recent years. The initial idea was to offer a Biennial Master's Course, consisting of two-day meetings every month for 10 months a year, where participants can learn about Jorge García Badaracco's theory.

The Master's course involves participation in:

- A monthly LIPsiM Seminar, which has been active since the Laboratory's foundation. The seminar is held on the afternoon of the third Friday of each month, lasts about two and a half hours, and includes a presentation of the theoretical part followed by free discussion with the participants.
- The MFPG, founded by LIPsiM members in 2016 and led by experienced multifamily psychoanalysts. The MFPG meets bimonthly on Fridays in sessions of one and a half hours, including the relevant Athenaeum (post-group meeting) of half an hour.
- Eight hours of theoretical lectures on the Saturday of the dedicated weekend, supplemented by viewing and discussion of video material related to MFP.

In the course of these years of training experience, several considerations have emerged within the LiPsiM teaching team, which have led to various transformations in the initial approach of the Master's programme. Since the participation of LIPsiM members in the MFPG at least once a month, if possible twice a month, has gradually become the elective place of learning, the LIPsIM teaching team has introduced the following changes:

- The start of the LiPsiM seminar has been brought forward to allow for a doubling of the time devoted to the Athenaeum from half an hour to one hour;
- Lecturers involved in Saturday's training activity would attend the MFPG and Athenaeum on Friday, so that the content of the lessons planned for the following day could be adjusted in the light of what had taken place in the MFPG and Athenaeum the previous day;
- Each student has to present an operational project on the start-up of a new MFPG to accompany the final theoretical paper.

These decisions were made in the context of the assessment that this way of working, which is still very much craft-based, is fundamentally based on what is experienced in the group and reworked in the Athenaeum, supplemented by the theoretical-methodological content of the following day's lectures.

Finally, we considered it optimal for each student to be supervised by one of the Master's lecturers, with a mentoring function implemented through periodic interviews (at least 3) during each year. The purpose of this initiative was to monitor each student's efforts to engage with a profoundly transformative theoretical approach to severe mental pathology, capable of challenging the thinking and clinical action of the so-called 'insiders' from the ground up.

It also seemed useful to provide students with a point of reference for the design of a new MFPG project to be launched at the end of the two-year Masters course.

1.2. Biennial Master in Multifamily Psychoanalysis

The Biennial Master's Degree in Multifamily Psychoanalysis is aimed at professional psychotherapists (psychologists or doctors) who wish to deepen their knowledge of the method and to train in the function of leading MFPGs. It lasts two years and has a theoretical-clinical-experiential structure. The aim of the Masters course is to train students in the use of an innovative prevention and treatment tool that can be applied in different contexts.

The duration is two years and has a theoretical-clinical-experiential structure.

The didactic methodology adopted aims to guarantee the theoretical-clinical-experiential dimension of the training experience through interactive monthly theoretical seminars, direct participation in the MFPG, the viewing of videotaped clinical material for training purposes and the initiation of a project related to MFP in the various application contexts. During each year of the course, each student will have at least three individual meetings with a reference lecturer in order to better direct their training.

The training course includes a monthly session (Friday afternoon and Saturday full day) at the Laboratory's headquarters in Rome and a fortnightly attendance at the LIPsiM MFPG. A week of intensive participation in the various MFPGs present in the Laboratory's territorial network is also desirable.

The theoretical corpus is rooted in the "Articulaciones" scheme (Annex 1) developed by Jorge García Badaracco, which is used as a basis for the teaching interventions; its complexity allows it to be used in a flexible and gradual way, according to the answers given by the students over time. Through the students' participation in the monthly seminars, we wanted to give them the opportunity to get to know the different multifamily experiences that have matured in Italy, allowing them to verify the implementation and applicability of the method in different national contexts and professional realities. The heterogeneity of the contributions favoured the development of the method in new contexts.

Participation in the MFPG is active and allows participants to directly experience the workings of the model, either for teaching purposes, as a trainee, or to continue working on themselves, as a group participant. After the group there is a post-group called the Athenaeum. This is a space to reflect on what happened in the group, both in terms of the dynamics that emerged between the participants and the experiences of the facilitators.

As mentioned above, over the years we have found it necessary to assign a tutor to each student with the aim of accompanying the student throughout the year, exploring any personal issues that may arise in the course of group participation, assessing how to support critical situations and focusing on the end-of-year work.

A minimum of three meetings per year with the tutor are planned.

Each year the students have to produce a theoretical paper and in the second year a project for the start-up of an MFPG in a context of their choice. LIPsiM has to support the creation of the group and the networking for the development of the project.

2. THEORETICAL AND METHODOLOGICAL CONSIDERATIONS

2.1. The scheme of the "Articulaciones"

Multifamily psychoanalysis is at once simple and complex, and demands to be thought of as a whole, an inseparable whole structured by multiple interconnected articulations.

This basic idea inspired Jorge García Badaracco to formulate the scheme of 'Articulaciones'. If we analyse this scheme, we can identify a central component, 'sabiduría' ('wisdom'), which is seen as a goal to be aspired to rather than concretely achieved, a mental attitude that informs the relationships built through the multifamily experience.

Next, we can divide the conceptual content of the scheme of 'Articulaciones' into three different types.

The first type includes the elements that should constitute and imply the 'method' (how the group works):

1. Respect is an essential requirement of the attitude of those who choose to participate in the MPG.
2. The MFPG must be seen as a permanent laboratory for the development of new ideas: nothing is taken for granted. On the contrary, each group can hide hitherto unimagined surprises, capable of challenging the deepest 'convictions' of all participants ('vamos a aprender').
3. Inspired by Edgar Morin, the importance of conversation as a means of stimulating the human capacity to move from action to commentary on an action, i.e. to change the logical level of functioning of the mind.
4. It is not the pursuit of 'knowledge' as an end in itself, but knowledge that enables those who acquire it to understand and help.
5. The MFPG aims to help those who have lost the belief that they can be helped to once again 'trust the other' and rely on someone else's help.
6. Disease develops over time, in relationships. We are all born healthy and can be considered potentially healthy.

The second type is made up of the elements that characterise the theoretical framework organised by JGB to conceptualise the phenomena that occur in MFPG (what the group is working on):

1. The phenomenon of 'los otros en nosotros': not only do we live in relationship with others, but we live in others; others inhabit us, we inhabit others. This is all well and good as long as it is a temporary phenomenon; but when it becomes permanent, even with a positive intention, it can lead to:
2. 'Pathological and pathogenic interdependencies', usually involving two members of different generations within the same family, typically a parent and a child; these occur when the parent(s) relate to the child as if it were part of themselves, and in which the child, having only experienced this kind of abusive relationship, tends to reproduce it with the parent(s), in a dimension of reciprocity. This can lead to:
3. 'Psychic suffering' because if someone else is constantly replacing us, we can no longer distinguish between ourselves and the other. This may be useful in the early stages of life or in exceptional circumstances, but if it continues over time it prevents people from becoming the 'subject' of their own existence. The patient appears to be a caricature of the

parent(s), as if trying to live up to their expectations and be the parent they are most attached to, rather than pursuing the development of their own personality.

4. The specific features of the MFPG stimulate the actualisation and re-enactment of pathogenic family dynamics, bringing out and exposing the mechanisms of imprisonment between the patients and one or both parents; very often the perception manifested by those directly involved is very different from reality.
5. It is at this moment that a lack of 'genuine ego resources' manifests itself. The functioning of the MFPG enables and encourages both patients and family members to rediscover and recover their 'genuine ego resources', allowing them to embark on a path of personality development and self-determination, discovering and developing their own
6. 'Healthy virtuality', present in everyone but which none of the people involved ever knew they possessed: the mind's ability to self-organise in order to neutralise and disarm the 'maddening presences' in the inner world and to dissolve pathogenic interdependencies with the outer world.

The third type takes us further by defining the framework of 'expected results', the objectives to be pursued (what the MFPG is working for):

1. Acknowledgement and understanding of the hyper-complex dimension in which the traumatic events we must refer to occur and in which we must try to understand the suffering of the people involved. This suffering is so profound that it leads to the partial or total abandonment of one's own life.
2. To develop the ability to listen to, recognise and express our own and others' emotions without letting them slip away. Emotions, especially the more complex ones, are rarely expressed clearly, they are at best hinted at; when they emerge they need to be grasped and developed, showing those coming from a repressive situation that it is not only possible but useful to integrate them fully into communicative exchange. To do this, we use metaphors, images and dreams, which simultaneously reveal and conceal, but can be ‘interpreted'.
3. Accepting that we do not always know everything, tolerating uncertainty and adopting a constructive attitude. First and foremost, it is the conductors who must abandon the attitude of those who consider it their primary task to put the patient in the right diagnostic box, but who must be able to listen and gather information in order to formulate hypotheses, while at the same time inviting and helping all participants to do the same.
4. Over time, as these "punti di repere" (points of reference) are activated and connected, the MFPG begins to function as a "mente ampliada", a definition used by JGB to describe how, in the group, the different voices and opinions of the participants do not oppose each other, but tend to gradually self-organise into a creative whole, generating a complex thought that is inclusive of all the opinions expressed. Individual minds begin to function in an open, integrated and enriching way.
5. With time and perseverance, the MFPG can become a multifamily community at work, a small society capable of tackling difficult challenges and complex problems.

2.2. The rules of the setting

Let us now look at the system of rules and the resulting considerations that characterise the MFPG as a setting.

The main rules are:

1. Each participant in the group should try to speak in the first person, avoiding as far as possible speaking on behalf of someone else, usually the 'designated patient'.
2. Each participant should not claim to be right, but should try to tolerate someone else suggesting something different from what has just been said.
3. Each participant may only speak after the intervention has been booked, refraining from immediately refuting/countering what another participant has said.

They appear to be simple rules of behaviour that allow one to speak to all those who wish to do so, but in reality they are methods of communication that are the antithesis of those used by members of a family with a psychotic or otherwise disturbed communication, in which each person claims to counter what the other is saying and to affirm one's own truth.

In this type of situation, it should be suggested how appropriate it is for each person to reflect on a personal vision of the situation and to be able to express it directly. Furthermore, if we manage to follow the third rule, we will be able to see how all the contributions, even if they propose different ideas, manage to coexist with those of the others and how, in the end, they all contribute to the formation of a single thought, which is what the group has spoken on that day (the 'mente ampliada' phenomenon).

Being able to tolerate a situation where different opinions are compared and where there can be convergence as well as divergence between people can be of great help to those trapped in the grey zone of psychosis.

2.3. Comments on the participation of professionals

In the MFPG, we can only work and try to reformulate the way we look at mental pathology through the joint work of all the institutional medical staff, or at least the staff on duty, made up of qualified specialists (doctors and psychologists) and other professionals with different training (nurses, social workers and psychiatric rehabilitation therapists).

During the MFPG it becomes possible to observe, approach and interact with the expressions of psychic distress in a way that is as close as possible to how they manifest themselves in family reality. This makes the multifamily experience particularly useful and fascinating, but at the same time surprising and sometimes disconcerting: one has to face reality without the mediation of the 'expert', renouncing the easy protection offered by the usual power relationship between doctor and patient.

However, all this has consequences that need to be considered:

1. Direct contact with suffering that is not mediated by 'knowledge' can be difficult; on the other hand, it can also create a strong sense of solidarity among group participants over time.
2. The immediate and authentic sharing of one's feelings involves a 'self-disclosure' which can be difficult and/or traumatic. The MFPG facilitates and encourages this experience, or at least reduces its intensity.
3. In order to be able to "fully share experiences", professionals must see themselves as equal to others, abandoning what normally separates them from patients and family members: it is a meeting between people.

3.TRAINING PROPOSAL

Conduction in the MFPG takes on a specific connotation in relation to the specific operating characteristics of the group.

Open group

The MFPG is an open therapeutic group at the different levels of its organization:

- It has a starting date but not an end date, it allows new participants to join at any time, and it usually does not activate selection procedures but only preparation for entry.
- It is open to the inclusion of different professionals belonging to the institutional context and integrates different training paths.
- Continuous attendance is desirable but not obligatory: everyone participates according to their needs and possibilities.
- The physical structure is also open: for example, a circular seating arrangement is preferred, which is not fixed in number or position.

The open functioning and structure of the MFPG require the Conductor to be flexible and receptive to the stimuli coming from the heterogeneous, multi-generational, often multicultural and multiracial group; the conductor must be open and flexible, but also firm in respecting the few rules of the setting and the ethical and deontological limits, guaranteeing the confidentiality and emotional security of the context. This implies that the conducting function goes beyond the time of the single meeting, presiding over the boundaries of the group and ensuring its continuity.

Self-eco-organization

Looking at the MFPG as a hyper-complex functioning system allows us to see clearly how mental phenomena are produced in an interrelational field in which the mental functioning of one depends on the mental functioning of the others, usually in a subliminal or even covert form; sometimes this reciprocal conditioning takes the form of an impediment to thinking and an obligation to behave as if one were being maneuvered from the outside. JGB writes:

"*In the operational reality of multifamily groups, it is not just a matter of interpreting what is happening, but of actively intervening in this paralyzing framework, disarticulating the pathogenic interdependencies and allowing the therapeutic resources (... of the group...) to work, which activate the self-organizing mechanisms of the individual human being and of family and social systems*".

When the individual/system is in a state of self-organization, it distinguishes itself from the environment and, at the same time, becomes more closely bound to it: it self-organizes in the sense that it establishes interdependent relationships with the environment... the more autonomous the individual is, the less isolated it is. To paraphrase Morin, the individual needs a constant exchange of food, energy, information and order. Stimulated by the conducting team, the group regains its natural power to self-organise, which has a powerful multiplier effect in enabling individuals to self-organise their minds.

As the group progresses, the function of conducting can be seen as a transversal function/resource of the whole group and the conductors/facilitators become equal participants in the group in terms of equal subjective contributions, facilitating the functioning of the group as a "mente ampliada".

3.1 The MFPG Conductor and Facilitator

The gradual refinement of the training proposal during the different phases of the project has made it possible to include among the addressees of the proposal mental health professionals who, although not psychotherapeutically trained, play an indispensable role in the functioning of the MFPGs; this evolution has made it possible to define the two different figures active in the team, the conductor and the facilitator, who, by integrating their levels of responsibility, enable the optimal functioning of the group.

The data from the research carried out in the first phase of the project show that more than 80 per cent of the participating MFPGs use a heterogeneous conducting team, regardless of the different methodologies adopted; in particular, the participation of the different figures is broken down as follows: 89 per cent psychologists, 56 per cent psychiatrists, 45 per cent nurses, 31 per cent social workers, 13 per cent educators, 11 per cent occupational therapists, 38 per cent other.

The Facilitator and the Conductor are new figures in the landscape of family interventions in mental health, born of a new paradigm, a new philosophy in the treatment of psychosis, and characterised by the specificity of the function of conducting MFPGs. As we shall see, they also represent an innovative element in the context of group therapies.

Indeed, one of the strengths of MFPGs lies precisely in the meeting and integration of different tasks and competencies within a conducting team.

The Conductor takes responsibility for the setting, ensuring the safety of the group by signing non-compliance and limiting destructive dynamics when the group is unable to do so (e.g. in the start-up phase or at times of crisis); as the group grows, the Conductor must be able to relinquish his or her central position and move into the background, facilitating direct exchanges between participants. In fact, the Conductor is the clinical, formal and legal leader of the therapeutic context.

Since the Facilitator does not have to take direct responsibility for the group, he/she can express his/her own feelings and experiences with greater freedom, helping the group to expand its emotional and thinking field; the Facilitator organizes his/her interventions on the basis of personal competencies acquired in clinical experience.

In the specificity of the conduction function in the MFPG, it is desirable that each member of the conducting team can cover and alternate these two roles.

The MFPG Facilitator: further considerations

We define a Facilitator as any mental health professional involved in the management of an MFPG who becomes an active part of the group's conducting team: nurses, social workers, psychiatric rehabilitation therapists, educators, social workers, but also psychiatrists and psychotherapists.

Twenty years of experience in different clinical contexts have shown that the presence of these professionals in the management processes of an MFPG is essential for the birth and rooting of the group in the institutional context, for its coherent functioning and for its transformative effectiveness.

Although the functions of the facilitator are in many ways overlapping with those of the leader, we would like to highlight some specific functions, both external and internal to the group.

External:

- Often acting as a "front office" in relation to patients and family members, the Facilitator is in a privileged position to convey the philosophy of multifamily intervention from the very first contacts and to facilitate participation in the group.
- By participating in multi-professional rehabilitation activities, the Facilitator helps to spread the multifamily culture in the institutional context.
- Moving in the transversal spaces of the institutional organisation, the Facilitator supervises the group and protects its boundaries, acting both towards the participants (ensuring communicative exchanges, reminding them of meetings) and towards the institutional context (safeguarding physical and relational spaces, ensuring correct behaviour).

Internal:

- As MFPG involves several families coming together in a group setting, the facilitation competencies of the conducting team play a crucial role in creating a safe and supportive therapeutic environment.
- When families come together in a group, conflicts and tensions can arise due to different perspectives, needs and communication styles. Competencies in conflict resolution through careful mediation enable the Facilitators to help families deal constructively with these challenges.
- By creatively using the characteristics of the multifamily context, the Facilitators can empower participants to develop new competencies by approaching issues with a flexible attitude and experimenting with coping strategies in a collaborative way. This approach provides adaptive support towards an increased ability to cope with tense and stressful situations, thereby increasing the potential for positive change.
- The presence of Facilitators allows participants to benefit from shared learning by observing and engaging with other families facing similar challenges, thus encouraging the active empowerment of each individual in the care process. This experience promotes a sense of universality, reduces feelings of isolation or stigma and contributes to a supportive and enriching therapeutic environment.

3.2. The Training Path

The training course is structured over three consecutive and interdependent years, with each level providing a specific professional certificate. This structure allows professionals who meet the requirements to advance in the training based to their motivation and aptitude.

First Year: this initial phase targets all mental health professionals (nurses, social workers, educators, psychiatric rehabilitation technicians, psychologists, psychiatrists, psychotherapists) who are interested in deepening the knowledge of Multifamily Psychoanalysis. Facilitators participate in this first year.

Second Year: this level serves as the initial training stage for Conductors and is specifically designed for psychiatrists and psychologists / psychotherapists. Participants who have completed the first year as Facilitators can extend their previous psychotherapy training by acquiring competencies in methodology and multifamily practice.

Third Year: this final stage is geared towards Conductors who, after completing the first two years of training, have developed a keen interest in PM and are keen on establishing and managing

MFPG in either the public or private sector. It involves the challenging process of initiating a new MFPG, requiring direct and assumption of project responsibility.

Structure of the training course		
Annuality	Recipients	Certificate
Year 1 140 hours	Mental health workers (nurses, social workers, educators, psychiatric rehabilitation technicians, psychologists, psychiatrists, psychotherapists)	Facilitator MFPG
Year 2 140 hours	Psychiatrists, psychologists, psychotherapists	Conductor MFPG
Year 3 60 hours	Psychiatrists, psychologists, psychotherapists	Expert conductor MFPG

The course adopt a progressive mode of training in PMF, which encourages a gradual introduction to an innovative paradigm in preventive intervention in Mental Health and in the treatment of mental distress. This approach seeks to maintain coherence within a complex, integrative and transdisciplinary framework. The challenge lies in ensuring that viewing these elements as an inseparable whole does not hinder a training approach that must be structured in successive sequences.

The progression in in mastering the content can be achieved through a tiered approach to participation in the training experience, which includes both theoretical aspects (interactive transmission of knowledge) and practical elements (learning by doing).

The training activities focus on enhancing competencies identified in the Matrix of Professional Competencies, which is organized in 18 families of competencies. These are grouped into three areas of specialization:

- Area of Strategic Knowledge
- Area of Strategic Therapeutic Management Competences
- Area of Personal Competence

That develop across the various levels of the "Articulaciones" framework:

- How the MFPG functions
- What the MFPG focuses on
- The objectives of the MFPG

Featuring an in-depth analysis of the contents of the Vademecum, structured progressively to cover:

- Theoretical foundations
- General recommendations for Conducting an MFPG
- Healing factors

Throughout all the three years, the training emphasizes the development of competencies outlined in the "Competences Framework" and the implementation of the third level of "Articulaciones". Starting from the third phase, monthly peer comparison meeting are held, coordinated by a Trainer. Each student is supported throughout the training by a tutor, who provides in-depth study, periodic assessment of learning and additional support in the final year

In the third year, which focuses on launching a new MFPG, the training involves direct participation by the trainer in the new Group and the subsequent Atheneo, interspersed with periods of "External Supervision". This supervision is aimed at overseeing the independent conducting work performed by the student in collaboration with the institutional management team.

The training incorporates a theoretical/ methodological learning level through monthly seminars, which are structured to facilitate interactive/group dialogues. This is complemented by experiential workshops and participation in an MFPG, led by at least one teacher/trainer. These seminars and workshops are integrated into the training as practical learning experiences. Both learning modes are connected and interdependent, crucial for the progressive acquisition of competencies as outlined in the "know", "know-how" and "know to be" framework identified in the matrix of professional competence areas.

For each year, the final evaluation will focus on the critical discussion of the end-of-year paper, the observations made by the tutor throughout the training process, and the competencies expressed by the student during the participation in the MFPG. The evaluation will be carried out by a team of at least three evaluators, including the tutor, each possessing substantial clinical and educational experience.

3.3. Facilitator and Conductor Competencies

Participants in the training program will gradually develop specific competencies to become Facilitators and/or Conductors through a blend of theoretical and practical activities tailored to meet the objectives for each year of attendance. The 18 competencies form an integral part of the professional baggage for both Conductors and Facilitators, with varying levels of mastery required.

When operating within the MFPG, it is crucial to recognize that certain competencies, especially those in the Area of Strategic Knowledge, are essential for both roles. These competencies are necessary to understand family dynamics and the interconnectedness of family members within the system. Additionally, two competences of the Personal Area, focusing on the cultural and ethical dimensions and the ability to transfer knowledge across different family and/or therapeutic contexts, are critical. These competencies provide the foundational technical background, acquired through both theoretical and practical training, for both the Conductor and the Facilitator.

The competencies in the Therapeutic Management Area are fundamental for managing the MFPG effectively. While the Facilitator must be aware of this competence, they are not expected to take active action or implement all the competencies in this Area during the first year. Instead, they will focus on developing excellent communication competencies and the ability to work with flexibility and adaptability, in a collaborative and facilitating environment.

The second year's activities are particularly aimed at developing, in the Conductor, the other 9 competences of the "Competence Framework". These competencies require proactive intervention in sensitive situations requiring diagnostic and assessment competencies, emotional sharing, and the application of specific competencies to manage conflict discussions and interventions within the framework of a systemic thinking that enhances facilitation and promotes resilience. These competencies should be enacted in an atmosphere of respect for emotions and openness to emotional learning.

The third year focuses on strengthening all 18 competences through their application in creative and original contexts, such as the establishment of a new Group of Multifamily Psychoanalysis. This phase also requires additional competencies related to design, interrelation with public and/or private organizations, and the evaluation of outcomes.

FAMILIES OF KEY COMPETENCES AND COMPETENCES PER YEAR OF ATTENDANCE	1° Anno	2° Anno
AREA OF STRATEGIC KNOWLEDGE		
1.To be able to consistently adhere to Psychoanalytic Thinking		X
2. To be able to promote a Systemic Thinking		X
3. To be able to focus on a Multi-Generational Approach in a Group	X	
4. To be able to use an approach based on Sharing (all kinds of) Emotions that arise in the group		X
AREA OF TRANSVERSAL THERAPEUTIC MANAGERIAL COMPETENCIES		
5 . To be able to use excellent Communication Competencies	X	
6. To be able to work for the re-Discussion of Conflicts		X
7. To be able to use a non-intrusive group conduction and maintain a Supportive and Empathic Climate	X	
8. To be able to take advantage of Groups Relational Dynamics, being aware of multi-transferences and enactments		X
9. To be able to work with Flexibility and Adaptability	X	
10.To be able to enhance Facilitations	X	
11.To be able to promote Resilience		X
12.To be able to use Therapy Open Format		X
13. To be able to encourage a Collaborative Exploration	X	
14. To be able to promote Shared Learning	X	
AREA OF PERSONAL, ETHICAL, SOCIAL AND CULTURAL COMPETENCES		
15. To be able to conduct Assessment and Diagnosis		X
16.To be able to improve his/her own Cultural Competence	X	
17. To be able to maintain Ethics and Boundaries	X	
18. To be able to be open for affective learning (through training, supervision and Ateneo, own therapy, …)		X

3.4. Objectives and organisation of activities

3.4.1 First year

In the first year, priority is given to activities and contents that develop the foundational competencies, aligning the roles of the the Conductor and the Facilitator within the group. The training objectives are primarily focused on developing the 9 competencies essential for facilitating the management and growth of the MFPG, as described in the first and second levels of the "Articulaciones" (how and on what the MFPG works), and the core contents of the "Vademecum".

Each student receives individual guidance and support from a tutor, enhancing the experience. A presentation of theoretical work at the year's end is mandatory. Successfully completing the first year enables participants to engage consciously in the transformative processes within a Group of Multifamily Psychoanalysis, with implications at a personal, professional and institutional level.

This completion also qualifies participants for a "Facilitator" certificate.

The year includes ten monthly theoretical seminars, each lasting eight hours and structured around interactive/group dialogue. These are supplemented by three-hour experiential workshops and concurrent participation in an MFPG, led by at least one teacher/trainer and integrated into the training program.

Each of the 10 monthly training modules, plus a final day for assessing the individual training path and discussing a theoretical/experiential work, is conducted over two consecutive days, totalling 14 hours per module. This amounts to 140 hours of teaching activity. The specific activities within each module are as follows:

FIRST YEAR - GENERAL OUTLINE			
Target group: mental health workers (nurses, social workers, educators, psychiatric rehabilitation technicians, psychologists, psychiatrists, psychotherapists)			
10 Modules organized into two days each	Contents of the 10 Modules	hours	days
	Presentation/ deepening of national and international multifamily experiences, presentation of works (articles, books, videos) related to PM issues	3	First day
	Participation in the MFPG with teaching function and subsequent participation in the Ateneo	3	
	Presentation and study "Theoretical contents" of the Vademecum in relation to the reflections on what emerged during the participation in the Group.	2	Second day
	Study of the contents of the first and second levels of the Articulations (how and on what the Group works)	2	
	Definition, deepening, exercise on the 9 specific and common competencies of the Facilitator and the Conductor	2	
	Conclusion with the vision of video material, bibliographical insights, practical exercises, linked to the contents addressed during the two days.	2	
TOTAL HOURS OF EACH MODULE		14	

The second and third years focus on developing the the specific competences of the Conductor.

3.4.2. Second year

In the second year, in addition to the enhancement of the 9 competencies outlined previously, the activities delve into themes related to the second level of the "Articulationes", particularly concerning connections with psychoanalytic epistemology, systemic and group psychodynamics. Special emphasis is also placed on the theoretical and methodological elements of the "Vademecum".

Similar to the first year, there are ten monthly theoretical/methodological seminars, each eight hours long, structured through interactive/group dialogue mode. These are complemented by experiential workshops and at least fortnightly participation in a MFPG, led by at least one trainer/teacher and integrated into the training pathway as a practical learning experience.

Each student receives support from a tutor focused on deepening their understanding of methodological and clinical aspects. Submission of a theoretical/methodological paper is required by the end of the year.

Completion of the second year equips professionals with the competencies to operate therapeutically within the MFPG and to integrate the multifamily methodology in their clinical practice. Successful candidates will receive the "Conductor" certificate.

The structure mirrors the first year, consisting of 10 monthly training modules, each spanning two days for a total of 14h. However, there is a variation in the final module, which includes the presentation of a project proposing the hypothesis of initiation of a MFPG, accompanying the year-end paper.

SECOND YEAR: GENERAL OUTLINE			
Target group: Psychiatrists, psychologists, psychotherapists			
10 Modules organized into two days each	Contents of the 10 Modules	hours	days
	Presentation/ deepening of national and international multifamily experiences, presentation of works (articles, books, videos) related to PM issues	3	First day
	Participation in the MFPG with teaching function and subsequent participation in the Ateneo	3	
	Presentation and study "Therapeutic Factors" and "Practical Recommendations" of the Vademecum	2	Second day
	Deepening of the contents of the second level of the "Articulaciones", in particular with regard to the connections with psychoanalytic, systemic and analytical group epistemology.	2	
	Definition, deepening and exercises on the 9 specific competences of the Conductor, included in the three Areas of the Competence Framework	2	
	The day ends with two hours dedicated to thematic insights of the content emerged in the two days proposed by the students through the use of video material, artistic productions, journalistic content	2	
TOTAL HOURS OF EACH MODULE		14	

3.4.3.Third year

In the third year, the focus extends beyond merely deepening knowledge and experience in participating in an MFPG. It shifts towards transforming these into operational practices through the founding and management of a new Group. This involves raising awareness and engaging other professionals from public or private organisation interested in developing an MFPG.

This year is characterized by "training on the job", where the student is supported by an experienced trainer/conductor. The conductor oversees the process through fortnightly meetings aimed at discussing various aspects of the project's design, preparing the operational context for the MFPG, assembling the leadership team, and initiating the founding process.

During these meetings, discussions cover the theoretical and methodological aspects related to the 18 competences of the Conductor and the implementation of the third level of "Articulaciones" (the purpose of the Group works). After the Group is operational, the training continues with alternating moments of direct participation by the trainer in the MFPG and subsequent Atheneo

Post Group moments of "External Supervision" regarding the student's independent conducting work in collaboration with the institutional management team. This constitutes ongoing monitoring of the training path, including specific moments of evaluation/adjustment related to the functioning of the new MFPG.

This approach facilitates a progressive refinement of the student's leadership competencies, starting from the handling critical situations, aiming to enhance the ability to learn from mistakes—viewed as opportunity for reflection - and to improve adaptability based on experience.

Monthly peer visitation/inter-peer service sessions are also included to foster direct exchanges and operational discussions among all students involved in the training process.

Concluding the third year signifies the student's capability to sensitize an institutional context to multifamily practices, to establish a management team, and to transfer knowledge and competencies to the operators involved in the MFPG. It involves a specific commitment towards the growth and spread of multifamily concepts and experience.

Participation in the third year leads to obtaining the certificate of Expert Conductor. The year includes 20 bi-weekly learning units of 3 hours each (60 h. total), during which each student is supported by a Trainer/ Expert Conductor. The training is segmented into stages that evolve progressively with project.

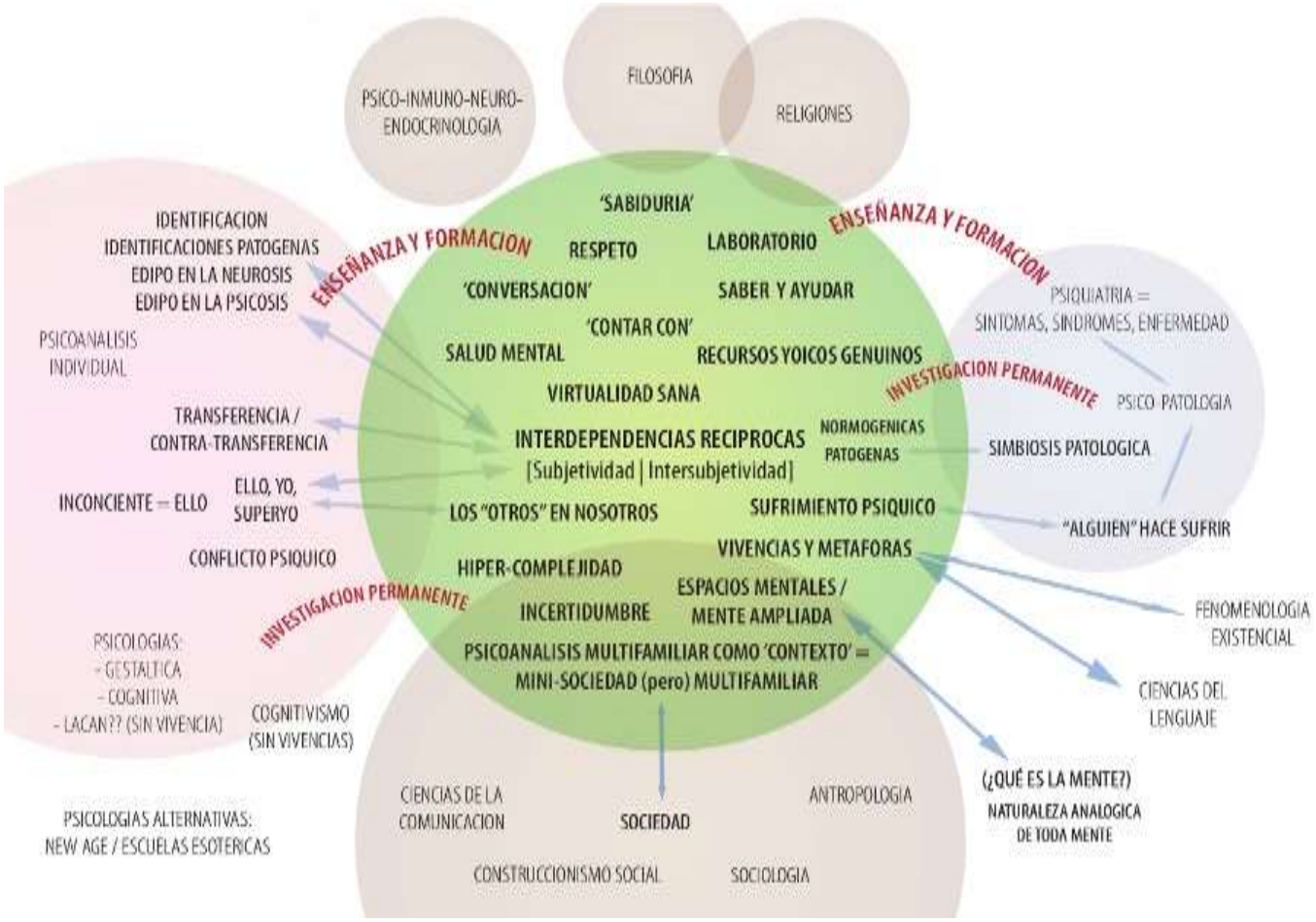
An end-of-year paper is required, detailing the project implementation and outcomes, a self-assessment of the training journey and acquired competencies, highlighting both strengths and weaknesses.

The evaluation of the project outcomes encompasses, in addition to the assessments from the previous two years, the verification of the activities carried out and their necessary adjustments, the evaluation of the MFPG's operation, and the assessment of the project's impact on the operational environment.

THIRD YEAR: GENERAL OUTLINE			
Activities	**Dating**	**Contents**	**Hours**
Planning	1	Institutional/context analysis	Fifteen Hours in two and a half months
	2	Definition of objectives and recipients	
	3	Identification of available resources	
	4	Definition of times and methods of implementation	
	5	Project Design and definition of the monitoring method and tools	
Context Construction/ preparation	6	Meetings with stakeholders and presentation of the project	Fifteen Hours in two and a half months s
	7	Team definition, roles and competences	
	8	Definition of the setting: location, frequency, times	
	9	Transfer of working and basic information	
	10	Ongoing Monitoring	
Foundation and start of the PMF Group	11	Project presentation at the Service/Institution	Thirty Hours in five months
	12	Contact and involvement of interested families	
	13	Start-up of the PMF Group	
	14	Group Conduction - Trainer participation in the MFPG	
	15	Group Management -External Supervision, Methodological Insights on the Conduct, MFPG Evaluation and Ongoing Monitoring	
	16	Group management -Direct participation in the MFPG of the trainer and competency check	
	17	Group management -External supervision, methodological insights on the conduct, evaluation of the MFPG	
	18	Group management -Direct participation in the MFPG of the trainer and competency check	
	19	Group Conduction - Visiting/ Peer Comparison	
	20	Visiting/Peer Comparison and Final Evaluation	
Monitoring and Evaluation	5	Monitoring and Evaluation	
	10-15	Definition of monitoring method and tools Ongoing monitoring of activities and expertise	
	20	Final evaluation of the completed project	

STRUCTURE OF THE TRAINING COURSE					
Annuality	**Target Group**	**Theoretical Area:**	**Experiential Area:**	**Final work**	**Certificate**
Year 1	Mental health workers (nurses, social workers, educators, psychiatric rehabilitation technicians, psychologists, psychiatrists, psychotherapists)	- 9 Specific competences -First and second level of the "Articulaciones" -Approach to the main contents of the Vademecum".	- Participation in a MFPG -Mentoring with the function of individual guidance and support in the elaboration of the training experience.	-Theoretical work is required.	Facilitator MFPG
Year 2	Psychiatrists psychologists psychotherapists	- 9 Specific competences -Second level of "Articulaciones", connections with psychoanalytic and systemic epistemology -Practical recommendations and therapeutic factors in the Vademecum	Participation in an MFPG -Mentoring with the function of individual guidance and support in the elaboration of the training experience.	-The submission of a theoretical work and the formulation of a hypothesis for starting a GMF	Conductor MFPG
Year 3	Psychiatrists psychologists psychotherapists	It is structured as an experience of "Traininig on the job", an individualized intervention divided into 4 Macro-Activities A- Design B- Definition and preparation of the operational/institutional framework C- Foundation and start of the MFPG D- Monitoring and verification			Expert Conductor MFPG

1. The “Articulaciones”



PART FOUR
"CONTRIBUTIONS FROM THE PARTNERS"

In this part are collected the contributions that each partner has considered significant to enrich the analysis. The contributions concern the diffusion of MFPG in their own countries and in-depth analysis of some specific aspects of multifamily psychoanalysis.

I - The impact of PMF on public and private health in the research participating countries.

II - Additional elements of the PMF.

A. SPAIN

A.I Impact of multifamily psychoanalysis in Spain
by Norberto Mascarò MasriSpain

In the late 1950s, Jorge García Badaracco began in a service of the psychiatric hospital José T. Borda of the city of Buenos Aires, a series of innovative experiences in the treatment of psychosis. Relying on the ideas of Maxwell Jones on Therapeutic Community, he introduces psychoanalysis in the treatment of severe mental pathology in that broad social context, there he begins to make multifamily encounters, where he observes, a particular dynamic in these groups that differentiated them from group and family therapy.

From this experience, a way of thinking and treating the disease arises, which allows the simultaneous approach of the individual, family and social dimension of the mind, which is constituted in an integrative model of its own, which it called, Multifamily Psychoanalysis. This model was nourished by conceptualizations of different psychoanalytic schools and other streams of group and family therapies, sifted by experience in multifamily groups, a process that he called "recontextualization of psychoanalysis".

García Badaracco's ideas on the treatment of severe mental pathology, through broad contexts such as the Therapeutic Community (Psychoanalytic Therapeutic Community of Multifamily Structure, 1990) and the Multifamily Group (Multifamily Psychoanalysis, 2000)are introduced to Spain through conferences held in Madrid and Bilbao from 1998 and which aroused a special interest in many mental health professionals and administrators.

After several years of disseminating his own ideas, through periodic visits, the arrival in Guecho, Vizcaya, Spain, of Norberto Mascaró, associate director of the DITEM Clinic directed in Buenos Aires by J. García Badaracco, occurred in early 1984. Hired as an advisor to an Experimental Center (Consorcio Uribe Costa de Salud Mental), whose mission was to implement an innovative psychiatry that integrated the different psychotherapeutic currents of the time.

Together with José María Ayerra and José L. López Atienza in that year, they put into practice the ideas of García Badaracco, transforming the Day Hospital of psychotic patients into a Therapeutic Community of multifamily structure, starting at the end of that year a Group of Multifamily Psychoanalysis that still works today. From this experience comes the work "The constitution of a Multifamily Group in a public institution" (N. Mascaró Masri, 2000).

Gradually, this way of working was disseminated through the annual meetings of Day Hospitals, national and international conferences and congresses. This was so, as this activity was extended to other public and private therapeutic areas, and also to the social sphere (schools, nonpsychiatric

hospitals, neighborhood associations, etc.). All these experiences were documented and presented at different congresses for discussion and dissemination.

Since the beginning of this experience, we have had the Basque Foundation for Research in Mental Health, OMIE), created in 1979 and which promotes knowledge in the field of Mental Health. In collaboration with health and educational institutions, it offers training courses in different areas of psychiatric/psychological work for health professionals. This institution allowed us to investigate the family and social factors that influence mental illness and to organize a formation on these multifamily groups, as well as to spread its doctrinal body that we call Multifamily Psychoanalysis.

Later, we received the support of a private institution in Bilbao (Avances Médicos) where at the beginning of the year 2000 we developed in his Day Hospital the ideas of García Badaracco on Therapeutic Community of Multifamily Structure and implemented several multifamily groups. In addition, this company financed the realization of two European Days of Multifamily Groups (2009 and 2015).

In 2000, the Institute of Multifamily Psychoanalysis was created in Buenos Aires, which carries out training and dissemination of this discipline. From the expansion in Spain of these ideas, doctors and resident psychologists, psychiatric nurses and social workers from the different provinces of Spain began to travel to Buenos Aires. In these more than 20 years about 600 professionals were trained, which allowed the realization of numerous multifamily groups in Spain, which currently exceed 60 throughout the territory, of which 28 participated in the research.

As we noted in the final report of this research (of the 28 respondents), we observed an irregular geographical distribution, demonstrating a concentration in some provinces and absence in the majority. In Madrid 9 GMF operate (4 in the community and 5 in the city of Madrid). In Vizcaya, 9 (6 in Bilbao and 3 in Guecho). In Granada, 2 (1 in the province and 1 in the capital). In Barcelona 2 in the city. In Elche 2, one in the city and one online for the community, and in Malaga (Marbella), Navarra (Pamplona), Alicante (city), 1 in each province.

It is significant that of 50 provinces and 2 autonomous cities in Spain, such multifamily groups are carried out in 8 provinces according to the surveys, although we know that these GMFs are also carried out in a few other provinces.

In 2017 we created in Bilbao, the Association of Psychoanalytic Psychotherapy of Couple, Family and Multifamily Group aimed at promoting and spreading the Multifamily Psychoanalysis through training courses, conferences and congresses.

There is no doubt that the impact of Multifamily Psychoanalysis in Spain was important, but much remains to be done in relation to the psychiatric and psychological care of patients and their families, both public and private. This perspective "humanizes" psychiatry and makes it possible, through bio-psycho-social treatment and especially with GMF, to care for more people with fewer economic, human and financial resources.

Finally, to mention that the MFPG is constituted as a "social laboratory" that allows investigating the complexity of mental phenomena and their interrelation with the surrounding world, enables the experiential learning of professionals and above all, facilitates the healing of participants.

The PMF provides a community assistance model, which allows addressing the different dimensions of the mind, in their individual, family and social aspects, as well as the family and

social problems in which individuals are immersed. Its potential for development ensures a promising future.

A.II Setting up a MFPG in a public institution
Norberto Mascaró Masri

First of all, I want to thank the organizers of these days, the opportunity to share with you a series of reflections on the Multifamily Group (GMF) and in particular to convey to you how we create a group of this nature in a public institution. This exciting, complex and enriching experience, although little widespread, opens new horizons in the search for a better care response to serious pathology.

My personal experience in this field began in 1972 in the framework of a C.T.P. (Psychoanalytic Therapeutic Community) that had been operating in Buenos Aires since 1968 and which had been created and directed by Professor García Badaracco, a pioneer in this type of experience.

Over the years, the GMF has proved to be a fundamental resource for addressing severe mental pathology. Patients and their families need a context in which they can express their personal difficulties, that is to say their "particular madness": This context will be made possible by the "others" capable of containing the most primitive and lacking aspects of mental suffering and allowing us to think the unthinkable and feel the unspeakable. The "particular madness" becomes everyone's madness."

We can sketch, that the expression of pathological conflicts in the dimension link is characterized by the presence of a type of pathogenic interdependencies lived with parental figures and that have in the internal world a current validity that tends to reproduce those pathological interdependencies in their present relationships. These situations highlight the so-called psychotic transference. The patients seem inhabited by multiple characters, often incompatible with each other, product of pathological identifications with the parents that have prevented the development of a self. Thus, the serious mental patient needs to be rescued from the "madness" in which he is immersed, that is, from the web of pathogenic interdependencies that have him trapped in the relationship with others and from the maddening objects that inhabit his inner world.

Next I will describe an experience in the constitution of a GMF in the year 1985, in the Day Hospital, of a Public Institution located in Guecho, Vizcaya. This Day Hospital, which operates according to the principles of C.T.P, was attended daily by 16 patients in a schedule between 9.30 and 13.30 h, where they performed a series of group activities complemented by individual and family therapies. The consolidation of the therapeutic system, following the principles of the CTP, as García Badaracco had developed in Buenos Aires, led us to face the challenge of setting up a multifamily group.

The therapeutic team that carried out the task, operated in coterapia and consisted of three psychiatrists, a psychologist and a psychiatric nurse. We all shared the interest in alleviating the mental suffering of patients and their families, and the need for an experience, which would reverse the existing pessimism in the treatment of these serious patients. It is noteworthy that the professional experience was not comparable in all the members of the team, which was not an obstacle to the task, since the coterapia was a magnificent means of learning, through clinical work and continuous reflection.

The need to create this resource, in terms of its therapeutic potential, was known by some and intuited by other team members. The beginning of the experience respected the evolutionary moment of the therapeutic team, which was just beginning its journey, taking into account its emotional capacity, psychological and formative to contain them intense anxieties that the various regressive moments produce and in turn contain the own anxieties product of the new experiences.

The best beginning was outlined to us as a group of families in which the designated patients did not participate. The destructive fantasies they produced by reuniting several families with their psychotic members were shared by some team members and their own family members.

The previous work with families to get their participation, focused on transmitting to them the importance of sharing with other families, similar difficulties in relation to the circumstances they lived. In addition, they were offered the possibility of learning in relation to the problems they had to face in the privacy of family life. After multiple meetings with each family, they were able to overcome the resistance of facing their own difficulties, often masked by fears and prejudices related to the rupture of their own intimacy.

So, we start meeting with families once a month. During the first year of work, the discourse revolved around the absent-present, that is, the designated patients.

First, parents were interested in the nature of the mental illness and what attitudes they had to take in situations unknown to them. A pedagogical attitude on the part of the team was extremely useful at the time. On the other hand, hostility was also beginning to appear among the absent-present, who were repositories of the most destructive and sadistic aspects of the progenitors.

In these initial moments, we never lost sight of the fact that our main objective was to mobilize defenses, analyze conflicts displaced to relationships and fundamentally take care of structural deficiencies and deep emotional needs, that as our work progressed we would find ourselves.

Despite this, the beginning was focused on containing anxieties, avoiding conflicts and mainly, relieving the intense guilt that these diseases generate.

The initial concern was to create an emotional climate of reliability, where we were not persecuted, but as people willing to help them. An active therapeutic activity with a dialogue dye, contributed to create that climate. We knew that therapeutic potentiality is not given by itself, but depends, according to our experience, on a way of doing special.

After a year of work, with the group quite consolidated, the relatives asked to increase the frequency of the sessions . They claimed it was the only space they had to talk about their problems; and in relation to their children, who had intensive treatment (4 hours per day, Monday to Friday), they had a monthly space, which was insufficient.

The team evaluated the request as important for the therapeutic process, and considered increasing the frequency so that we went on to meet fortnightly.

During the development of the Multifamily Group, we moved from that circular discourse focused on patients to sharing painful living situations: deep anguish, intense guilt, insecurities, frustrations and an intense pessimism that was the main barrier that found the therapeutic process of these people. Thus, a therapeutic culture was created where what happened to the designated patients was not so different from what happened to themselves. The inclusion of family histories, in terms

of their origins, also helped to understand that mental illness has a history and that everyone can be victims of unpredictable situations that decide our destiny.

Gradually, a hope appeared that things could change, and that a more fulfilling life could be realized.

This group development allowed parents to perform their own therapeutic process; Thus, different evolutionary moments were observed in them, which usually led the older ones to assume co-therapeutic functions. What better, than a mother or father who went through situations of intense psychological suffering, to understand and transmit a hope, to other parents in a time of crisis.

After about two years of work, once the group was consolidated, the need to physically include children began to be visualized as a way to deepen the problem. This situation was shared with the relatives, who at first expressed a manifest rejection, who settled on fantasies, already note destructive and catastrophic; although, some members of the team counteridentified with these paternal aspects, opposed inclusion under the pretext that those parents were deprived of the only place they had as their own. Unconsciously they lived the situation as if we were playing a battlefield where the children would destroy their parents. Other members of the team, however, bet `for a more complex and difficult task, but at the same time more rewarding.

The inclusion of designated patients was carried out gradually and it was observed that the dialogue was deepened. The initial aspects of the impending catastrophe were not fulfilled and the group has been around for 15 years. The meetings are weekly and about 30 people participate.

In terms of therapeutic work, we would like to emphasize that, working from a psychoanalytic perspective, interpersonal relations of a narcissistic nature, where verbal and non-verbal communication are at the service of control and not information, is the recognition of the other as an independent being.

It is observed how the difficulties of the parents, what García Badaracco calls lack of iodine resources are compensated through massive depositions, generating pathological complementarity relationships.

Any situation involving discrimination or autonomy in the sense of psychological growth is experienced as a threat to a family balance. Thus the order of perverse homeostasis is established. This emotional climate over time favors the introjection of pathological relationships, which recreated in the internal world of each member of the family, constitute what García Badaracco calls the maddening object , which acting dissociately in the mind contribute to create a pathological and pathogenic situation.

The team then, working in cross-examination, will make a reading of the unconscious phenomena that determine a special dynamic in the group. On the other hand it will analyze the characteristics of the personality of its members, the type of manifest communication, the assumed leadership and the established role play.

The greater emotional and intellectual demands to which the group therapist is subjected, turns this shared procedure into a resource of great therapeutic efficacy to face complex and difficult phenomena.

I referred earlier to the importance of this procedure in the training of group and family therapists.

To conclude, I would like to emphasize some aspects of clinical work.

First, there is the need to foster an emotional climate that facilitates communication and trust. For this it is important that team members find the right dialogue for each situation. Sometimes making contact with a given situation requires teaming up with symbiotic aspects of the multifamily group. Bearing in mind that these pathological modalities translate the existence of profound deficiencies and hidden emotional needs and not shared healthily, which prevent the possibility of an elaborate thought. Many times a therapist is "immersed" in these situations to be invested with intense transferential aspects, but always has the presence of others who act as a safeguard of experience, by speaking at another level interpreting what happens in the session. This provides the necessary food to continue the task. This operational complementarity will allow roles to be exchanged and constitute a dialectical process in which the family is included.

This way of working, requires on the part of the team, a capacity of self-analysis and reflection to face the anxieties that emerge in the task, as well as the divergences, that settle many times on latent rivalries, but which correspond to intense transferential impacts, which determine a special dynamic in the equipment that if not elaborated will become as resistance in the work with the multifamily group. The analysis of the so-called countertransference in a broad sense is an essential element for carrying out the task.

B. PORTUGAL

B.I History of Multifamily Groups in Portugal
Paula Godinho

Multifamily Groups,(MFG) bringing together at least two generations and involving the presence of patients in treatment, originated in Portugal in 2001 at the Day Hospital of the Psychiatry Service of Santa Maria Hospital, currently designated as the Day Hospital of the Psychiatry and Mental Health Service of Santa Maria Hospital/Department of Neurosciences and Mental Health of the University Hospital Center of Lisbon-North (CHULN).

The Day Hospital was the pioneering inpatient unit inaugurated in the Psychiatry Service of Santa Maria Hospital in 1957, marking the establishment of the first Psychiatry service in Portugal integrated into a General Hospital. It was founded by the first Service Director, Professor Doctor Barahona Fernandes, who instilled an institutional culture of pluralistic coexistence.

The current operational model began in 1977 with a group of psychiatrists: João França de Sousa, César Vieira Dinis, Isaura Manso Neto, and Sara Ferro. They developed a predominantly psychoanalytic and group-analytic model operationalized in a group setting, where the therapeutic team has always played a crucial role. This model encompasses therapeutic, training, and research objectives.

The Day Hospital of Santa Maria Hospital was developed based on the model of the João dos Santos Seminar (França de Sousa, 2013), a pioneer in modern Child Psychiatry and Mental Health in Portugal and one of the founders of the Portuguese Psychoanalytic Society. Dr. João dos Santos studied and worked in France with Henri Wallon, G. Heuyer, J. Ajuriaguerra, H. Ey, A. Thomas, René Diatkine, Jacques Lacan, Sacha Nacht, Pierre Luquet .and Serge Lebovici.

The impact of this reference unit in Portugal, in treating patients deemed "difficult," and in the education of undergraduates and postgraduates, was primarily documented in the works "Treating and Training - A 30 Years Experience of a Team with a Group-Analytic Framework." It received the Jane Abercrombie Award granted by the Group Analytic Society (London) in 2008 (Neto, Fialho, Godinho, and Centeno, 2010).

Since its inception, treatment at the Day Hospital has emphasized the importance of family interactions and relationships in the origin of pathologies and the therapeutic evolution of patients. In the early years, families were invited to participate in the therapeutic process, with interviews conducted for diagnostic and therapeutic purposes. For many years, Isaura Neto organized parent groups without the presence of patients. These exclusively parental groups allowed for the collection of clinically relevant data that could not be directly used in patient treatment due to confidentiality reasons.

In 2001, at the 3rd European Congress of the European Association of Psychopathology of Children and Adolescents with the theme "Psychopathology and Parenthood," held in Lisbon, Isaura and I browsed, as usual, the books that had just arrived from across the Atlantic. We found "Multifamily Psychoanalysis" by Jorge García Badaracco, recently published, which we decided to buy. Immediately, Isaura Neto organized its reading by distributing chapters among Maria João Centeno, Teresa Fialho, nurse Pilar Marques, and the rest of the Day Hospital team. After completing the book reading, the first Multifamily Group (MFG) in Portugal was born immediately, which has continued uninterrupted to the present day.

The Multifamily Group of the Day Hospital is a semi-open, slow-open group (without a start or end date, new members replace those leaving), heterogeneous in terms of diagnosis, with a biweekly frequency, a duration of 2 hours, and is led by a multidisciplinary team. Over these 22 years, it has undergone some adaptations. In the early years, it included only patients who were financially dependent on their parents, excluding patients who were already living independently. Later, it began to include all Day Hospital patients, also expanding the presence to other family members and significant individuals. Thus, parents, spouses, uncles, cousins, siblings, grandparents, etc., started participating, having already simultaneously gathered three generations and more than 50 people. During the Covid-19 pandemic, the groups operated online for about 2 years, later returning to the current in-person format.

Since the beginning, this MFG in Lisbon includes the presence of external observers, which led to its dissemination in other institutions in our country: in the Day Hospital of Fernando da Fonseca Hospital (Godinho, P; Dias, M.J, Matos, M,.2004) and, in 2006, in the Day Center of the Addiction Treatment Institute (IDT), later in the Day Hospital of the Psychiatry Service of Egas Moniz Hospital/Western Lisbon Hospital Center, and in Therapeutic Communities: at the Romão de Sousa Foundation (Estremoz) Community Life and Peace (Fátima), etc.

Health services in Portugal are in a phase of restructuring and reorganization. The potential of MFGs extends from mental or physical illness to health, from hospitals to the community. Recent Portuguese legislation emphasizes the importance of integrating hospital and community health care, particularly in the field of Mental Health. We face the challenge and multiple opportunities for greater dissemination of this powerful transformative device, a generator of dialogue, and a school of humanity.

B.II- The "Open-Door Syndrome": A Diagnosis Based on a Multifamily Group

Maria João Centeno[4]; Paula Godinho[5]; Teresa Fialho[6]; Ana Luísa Teixeira[7]; Isaura Manso Neto[8]

SUMMARY

The authors established a Multifamily Group (MFG) at a psychiatric Day Hospital in a major university hospital centre in Lisbon, catering to acute and severe patients. This Day Hospital (DH), operating since 1997, adopts a primarily psychoanalytic and group-analytic framework.

The MFG stands as an innovative psychotherapeutic tool founded upon Jorge García Badaracco's Multifamily Psychoanalysis that has been integrated into the DH Psychotherapeutic Program since

[4] Psychologist, Master in Educational Psychology, Group Analyst, member of the Sociedade Portuguesa de Grupanálise (SPG), working in the public sector at the Day Hospital of the Psychiatry and Mental Health Service at the Hospital de Santa Maria (HSM), and in private practice.

[5] Consultant Psychiatrist, Team Leader of the Day Hospital of the Psychiatry and Mental Health Service at HSM, Department of Neurosciences at CHLN, Postgraduate in Mental Health, Master in Bioethics, Psychiatry and Mental Health Lecturer at the Faculty of Medicine of the University of Lisbon, member of the International Association for Couple and Family Psychoanalysis (IACFP).

[6] Clinical Psychologist, Master in Clinical Psychology, member of Sociedade Portuguesa de Psicoterapias Breves, working in the public sector (Day Hospital of the Psychiatry and Mental Health Service at HSM) and private practice.

[7] Psychologist, Group Psychotherapist, Member of the Sociedade Portuguesa de Grupanálise, voluntary intern at the Day Hospital of HSM, Director and Group Coach of CIGA-Coaching de Inspiração Grupanalitica® at MRINetwork Portugal.

[8] Psychiatrist, Chief Hospital Service, Group Analyst, Training Analyst and president at the SPG, full member and elected member of the Executive Committee of the Group Analytic Society - London (GAS), having worked in the public sector (former Team Leader of the Day Hospital of the Psychiatry and Mental Health Service at HSM), currently in private practice.

April 2001. The MFG encompasses patients, their close relatives, and the clinical team, spanning at least two generations.

In addition to its therapeutic objectives, the MFG serves educational and training purposes for various healthcare professionals - namely, psychiatrists, psychologists, and nurses - engaged in internships at the Day Hospital.

Here, the authors briefly overview the MFG's characteristics, situating it within the DH context. They draw attention to a set of signs and symptoms associated with pathological symbiosis and the lack of boundaries within certain families. These manifestations become apparent through intrafamily interactions replicated in the MFG. The authors have coined the term "Open Doors Syndrome" to encapsulate this array of signs and symptoms.

Keywords: Family, Hospital Day, Multifamily, Psychiatry, Syndrome.

"When a door closes, a window opens"

(popular proverb)

INTRODUCTION

The Day Hospital

The Day Hospital is a Psychiatric Unit within a large university hospital centre in Lisbon, dedicated to the treatment of severe mental illnesses. Established in 1977, this Day Hospital (DH) operates primarily within a psychoanalytic and group-analytic framework, treating patients, predominantly young adults, afflicted with anxiety and mood disorders, as well as psychotic decompensations often linked to personality disorders.

In the DH, the therapeutic programme features individual and group activities, encompassing a psychotherapeutic analytic group and, since 2001, a multifamily group (MFG) based on Jorge García Badaracco's Multifamily Psychoanalysis. The MFG includes patients, their close relatives, and the clinical team, spanning at least two generations.

What distinguishes this group from other therapeutic settings is its unique capacity to directly observe familial behavioural and relational patterns, which spontaneously manifest within this setting.

Throughout its existence, the DH Team has been aware of the significance of family relationships, both in the origin of pathologies and in the therapeutic progress of its patients. Irrespective of nosological diagnoses, many patients reveal pathological interdependencies such as pathological symbiosis. Within these families, certain members engage in pathologically interdependent relationships, failing to recognise differences, exerting control, and being intrusive. In other words, they disregard or reject the existence of psychological boundaries. Interestingly, we observed a correlation in these families between the absence of psychological boundaries and the absence of physical limits within their living environments.

The Team and the Patients

Individuals undergoing treatment at the Day Hospital often exhibit some of the following characteristics:

1. History of previous treatments in other settings and under different approaches, carried out with little or no success.

2. Severe symptoms of depression and anxiety.
3. Suicidal ideation and suicidal and self-harming behaviours.
4. Substance abuse, engagement in risky behaviours, and challenges in social adaptation.
5. Limited autonomy.

In a psychodynamic analysis, these patients demonstrate a psychological functioning characterised by:

1. Early disturbances on object relations.
2. Predominant separation anxiety.
3. Poorly cohesive and narcissistically deficient selves.
4. Fragile egos and inadequately organised superegos.
5. Pronounced affective instability, stemming from the continual repetition of the idealisation/ de-idealisation process.
6. Weak or insufficient defence mechanisms, resorting to primitive defences like clivage, projective identification, idealisation, and denial.
7. Deficits in mentalising psychic life.

Multifamily Groups and Families

The Day Hospital Multifamily Group is a therapeutic initiative that evolved from clinical work with patients and their families, lasting 120 minutes every two weeks.

As familial engagement with the group intensifies and their confidence in the facilitators deepens, the shared exploration of psychic contents becomes more apparent through group interactions. These interactions demonstrate how, for instance, the children's dissent towards their parents, often reflective of an attempt to differentiate themselves from their parents, serve as the underlying cause of familial conflicts and tensions. These conflicts perpetuate pathological and pathogenic bonds, impeding the development of autonomy.

In these families, the challenge of remaining together and the impossibility of separation are palpable. The absence of individuation turns the family into a projection of an undifferentiated collective body, where otherness goes unrecognised. The prevalence of the "unspoken" dominates in these families, whose bonds aim to keep the psychic suffering that cannot be contemplated denied and/or repudiated.

The obvious difficulties in mentalisation result in prioritising action over thought and symbolisation, progressively eliminating the potential for organising themselves as distinct individuals. Instead, individuals become trapped in repetitive cycles with no apparent exit. Deviant parental behaviour, such as incest or incestuous conduct, often manifests itself, with roles and positions within the family interchangeably shifting. This underscores the absence of boundaries for the self. In such contexts, authority and otherness go unrecognised.

Children often adopt the role of caregivers for their parents, being frequently compelled to mediate in marital conflicts, even having to intervene to prevent physical aggression between their parents. Furthermore, children may find themselves entrusted with their parents' intimate sexual disclosures, initially appearing as a flattering gesture but ultimately proving to be a detrimental gift, as this can contribute to the disruption and disorganisation of their personality and sexuality.

In this context, Racamier (2010) introduced a pathology within the realm of narcissistic seduction, which he labelled as "incestual." This denotes a form of family group organisation that deviates

from the oedipal structure, typically linked to triangulation and the prohibition of incest. Put simply, it represents an atmosphere in both individual and collective life characterised by incest, without necessarily involving aspects directly associated with genital concerns. This entails a blurring of boundaries between public and private spaces. All boundaries are inadequately defined, with the only distinct boundary being the one imposed on the external world, depicted as perilous and threatening. Clear demarcations between the private lives of the family and the children are absent, a situation often manifested in the utilisation of physical space within the home.

The house, as a physical space, serves as a paradigm for the establishment or absence of limits. It can be a place that is either open or closed to external observation, with or without internal barriers. This space can be either regulated by rules or constraints or a transparent area without limits, where every place belongs to everyone and no one. The internal space of the house encompasses its walls and doors which act as separating elements and markers of the other's space, or lack thereof. In their transparency or opacity, they engage in a kind of "game of hide and silence, or reveal, see and hear." The house can be a stage for both conquests and compromises, order or chaos, a secure haven or, conversely, a place that poses a threat to integrity and individuality.

In numerous families, everything is transparent and open: the door to the parents' bedroom remains unlocked. Similarly, children are not permitted to close the doors to their bedrooms or even the bathroom, and their entitlement to privacy is neither acknowledged nor respected. Frequently, children, whether teenagers or adults lack an individual bedroom or bed. Some share sleeping quarters with their parents, grandparents, or other relatives, a practice accepted without criticism. In many households, doors lack keys, or the locks have intentionally been damaged, preventing them from being secured.

Multiple family members simultaneously use the bathroom without any sense of intimacy or discretion, maintaining exaggerated physical proximity, sometimes under the guise of monitoring and maintaining hygiene or health. The trivialisation of these aspects emerges as a significant barrier to identifying the incestuous dynamics in the clinical setting. Parents perceive anything not openly shared by their children as inherently objectionable and inappropriate, rebelling against non-transparency. The children, under careful control, are frequently discouraged from establishing contacts outside the family, ostensibly for their protection.

In a Multifamily Group (MFG) session, a patient's mother shared that she had a habit of sitting next to her daughter when she was using the computer to chat with her friends. She expressed confusion over her daughter's objections, reasoning that if her daughter claimed she was not engaged in any inappropriate activities, there should be no issue with observing whom she was talking to and the nature of her conversations with friends.

Another mother expressed her perplexity about her daughter’s need to call and spend time with her friends when, in her view, the parents could provide more assistance than anyone else. She explicitly disagreed with her daughter's preference for conversing with friends rather than the family, asserting that trust should exclusively be placed in the family. This same mother disapproved of her daughter isolating herself in her room. In response, the daughter explained that she simply required personal space and welcomed people knocking on the door to signal their arrival. The mother critiqued this attitude as unreasonable and unnecessary, interpreting it as a sign that her daughter likely had something to hide.

The parents of another patient explained that no doors were locked in their home. They had removed all the locks a few years ago to prevent their son from isolating himself, stating that locking doors was unnecessary because, in their perspective, there was nothing to hide. One of the therapists inquired about what they thought would happen to their son. The mother responded, expressing uncertainty, that "maybe he might feel unwell or be in a situation where he could die alone, with no one being able to help him.".

The father of another patient shared that during his son's childhood, he removed all the keys from the doors due to concerns that something might happen to him. Even after the keys were reinstated, doors were left unlocked.

Another patient complained that she could not close the door to her bedroom because her mother turned the key in the lock, leaving the latch outside and making the key disappear.

These excerpts from the MFGs elucidate the continuous monitoring of the children and the hindrance to their privacy, indicating the parents' incapacity to recognise and comprehend their need for differentiation. We term this collection of clinical elements the "Open Door Syndrome," representing a paradigm of intra-family challenges in attaining autonomy.

CONCLUSION

We assert that, as clinicians, we must increasingly be attentive to the relational and behavioural patterns within the family unit, recognising that even seemingly normal behaviours may conceal significant psychological disturbances. Within the context of the inability to break symbiotic bonds, incestuous tendencies may emerge as the sole defence mechanism against the feared separation.

It appears important to inquire about the family's hygiene routines and characterise the physical space, examining how it is utilised and shared by various household members. This exploration can unveil concealed dimensions of individual and family dysfunctionality. Also, it is recommendable to pose questions, as individuals may not voluntarily disclose or express concerns. They often perceive as natural and trivial certain behaviours and habits that, upon closer inspection, reveal themselves to be highly pathological and pathogenic. This approach can serve as a pathway to unveil hidden secrets and unspoken truths, below the surface of the assumed family equilibrium.

This dysfunctionality can often be diagnosed only by questioning the most fundamental privacy conditions within the family. Questions regarding individual bedrooms, sleeping arrangements, the practice of closing bedroom and bathroom doors, solitary bathroom use, and the courtesy of knocking before entering are crucial.

Inquiring about these aspects in adults remains an area where mental health professionals seem insufficiently attentive. We emphasise the significance of investing more in raising awareness, training, and preparing healthcare professionals, as well as the need for creating programs dedicated to the early detection of family dysfunction, often veiled as normalcy.

Within the household, closing doors is necessary so that windows can be opened to the world.

C) BELGIUM

C.I Multifamily Psychoanalysis in Belgium
Martine Lambrechts

Multi-family psychoanalysis came to Belgium in 2015. At the ISPS Congress in New York (2015), Dr. Andrea Naracci and Catherina Tabasso showed a video of their multifamily work in Rome. Deeply touched, we were immediately convinced of the powerful potential of bringing families together in healing and understanding a psychotic crisis.

Martine Lambrechts (psychologist/psychoanalytic psychotherapist) brought this experience to her workplace, the psychosis care program at the University Psychiatric Center Z.Org KULeuven (Kortenberg). Together with Jef Lisaerde (psychologist/systemic psychotherapist) they start a Multi-Family Group targeting young adults with psychotic vulnerability, who are in care in 2 different places:

- At the hospital ward, Joris, which offers a therapeutic and structured environment, combining principles of a therapeutic community (Ciompi) with the ideas of institutional psychotherapy (Oury). The department has a long tradition with single family work, inspired by the tradition of the Open Dialogue model and enriched by the interpersonal psychoanalytic ideas of Bion and Winnicott, among others.
- Within an outpatient early psychosis service, VRINT, located in the heart of the city of Leuven (10 km from the hospital). This service seeks to provide low-threshold, needs-based care to young people with early signs of psychosis and their families. In line with the dimensional and diagnostic model of Van Os and Kapur, it renounces the pessimistic view of psychosis and schizophrenia and tries to install hope while working with the psychotic patient.

A privileged collaboration exists between the inpatient ward and the outpatient service, as both often work with the same patients at a different time of their illness. Consequently, it was rather "natural" to organize an MFG focused on patients and their families within these 2 services. The first meeting takes place in January 2016. This is reported on by Martine Lambrechts and Jef Lisaerde at the 2017 ISPS congress with a lecture entitled: The start-up of a multi-family group for young psychotic patients and their families within a systemic and psychodynamic framework.

The MFG gains gradually more support within the teams of both services. To also give them the opportunity to know better the fonctioning and theory of the MFG within the framework of Garcia Badaracco, a working visit to Rome follows in 2018 with a delegation from Vrint and Joris (Sophie Guiot (psychiatrist/supervisor ward/ psychoanalytical therapist), Niel Van Cleyenbreughel (psychologist/ psychoanalytical therapist), Saskia Verbesselt (nurse), Leen Lambrechts (nurse), Jef Lisaerde and Martine Lambrechts. They participate in some MFG in Rome, guided by Andrea Naracci, Catherina Tabasso and their team. In addition are theoretical sessions on the principles of Garcia Badaracco's work.

In 2019, Vrint and Joris decide to split the joint group for practical reasons. This creates two multifamily groups according to Garcia Badaracco's model, one in Vrint and one in Joris. About the relaunch of the group at the inpatient ward is reported at the ISPS congress in Rotterdam (2019), under the title: The pregnancy of the MFG baby - becoming MFG parents.

Both MFG groups then go through a different progression, amplified by the arrival of the pandemic. Vrint chooses to make the digital group, while Joris chooses to interrupt the group and restart in 2021. Meanwhile, both groups have their own identities. Embedding them in each service's own therapeutic operation also raises new questions about technique. Witness the lecture at the ISPS Congress in Peruga in 2022 - When the body is invited to speak: raising hands as technique in the MFG.

Through Mariska Christiaenen (psychologist/ systemic and psychoanalytic psychotherapist), working in the MFG at Vrint, and educator in the postgraduate/training program in Psychoanalytic Psychotherapy at the Catholic University of Leuven, Multi-Family Psychoanalysis enters the curriculum of therapists in training.

The field research within the framework of the Erasmus+ project teaches us 2 important things about Multi-family psychoanalysis:

- The existing MFG in Belgium orient itself according to two currents: a more behaviorally oriented MFG, in which work is done with protocol and closed groups; a more systemically oriented MFG, working with open and continuous groups. The psychoanalytic MFG, so far unknown within Belgium, seems to be closer to this second tradition.
- In the focus groups, it became clear that there is a great need among MFG therapists for training and intervision.

The project has achieved to put Multi-family Psychoanalysis on the map, and to take a leading role to further develop training. Through the project, it becomes clear that the impact of MultiFamily Psychoanalysis needs further to develop in two ways:

- Bottom-up - starting from clinical practice:

1. In the follow-up of the Erasmus+ project an application is made for a new grant to support the start-up of a new multi-family group for young people aged 15 to 25 (transition age) with mental difficulties, who are on the waiting list for admission at a ward in the University Psychiatric Hospital Z.Org (Kortenberg). Included is this project is also the training of the new colleagues, who will participate in this group.
2. Further develop the network of MFG-therapists, therefor we organise a meeting with all interested MFG-therapist on our study day in January.

- Top-down - by initiatives on the organisator level:

3. In the psychiatric centre, with the possibility to further develop the MFG both clinically as at the level of organizing training.
4. At the Atheneo, where the place of the MFG can develop further in the postgraduate training of therapist and as a phd-project at the clinical department.

C.II The start-up of a multifamily group (MFG) for young psychotic patients and their families within a systemic and psychodynamic framework

Martine Lambrechts and Jef Lisaerde

Introduction

We intend to give an idea of the process of the start-up of a multi-family group. First we want to take a closer look at how to understand a psychotic crisis in a family context. Next, we'll present the authors that inspire us to organize a multi-family group, and will formulate the therapeutic

aims and the characteristics of our MFG. Along the way, we will indicate the obstacles, questions and doubts encountered, and highlight the aspects that seem to work.

Understanding of a psychotic crisis

Garcia Badaracco speaks about psychosis in terms of 'pathological interdependency'. Although we can understand this concept on a theoretical level, it is harder to think in this way sitting in front of the parents. We make a small detour to better understand this concept.

Taking the relation as focus in care, it is important to note that a concrete, external, interpersonal relation (expl. mother – child) is not equal to the internal representations of this relation inside the psyche of a person, namely the object relations. Without presenting a complete theoretical lecture of the object-relation tradition of Klein, Bion and Winnicot, we will formulate only some of our clinical intuitions.

We consider our working field the space that unfolds between the child and parents on the intra-psychic level of each one. We talk about the intra-psychic inter-connectedness, pointing out the interwined affects, feelings and thoughts. This relational, unconscious, interchangeable field is very complex. Essential basic mechanisms at work in this interplay between internal and external reality are projection, projective identification and introjection.

Taking the relation as focus has important repercussions on the understanding of the etiology, nature and treatment of psychosis.

On the level of the external relationships, we see how they are put under large pressure by the outbreak of psychosis. The psychotic state evokes a lot of anxiety and misunderstanding in the near environment. This is how the mechanism of psychosis works: it installs a cleavage between the 'sick' (crazy, non-understandable) young adult and the 'healthy' (rational, knowing) environment.

We could understand this cleavage as the projection of an internal, two-fold condition. Following Bion, we can differentiate a psychotic and a non-psychotic part in all of us. Richard Lucas explains Bion's ideas in a very clear way in his book 'The psychotic wavelength' (2009):

'Bion suggests that from early on in life, a separate psychotic part attacks all the aspects of the mind that have to do with registration of awareness of internal and external reality. However, contact with reality is never entirely lost, due to the existence of a non-psychotic part of the personality that functions in parallel with the psychotic part, though is often obscured by it.'

In this way, we understand the fragility of the psychological equilibrium in every one of us, and how we are all vulnerable to a psychotic way of functioning.

What mechanisms can play a role in the outbreak of a psychosis?

On the side of the parents

Searles points out that parents – in defense of their own psychotic way of functioning – can shift/project their psychotic part into the relation with their child. In line with this, Narracci (2008) puts forward the hypothesis 'that during their development the children were the object of massive projective identifications on the part of the parents, through which the parents displaced into the children a series of affective fluctuations that they could not keep within themselves'.

Contrary to what is often thought, we don't relate this projection necessarily with serious psychic disorders of the parents. We consider that this unconscious mechanism serves to protect the ability of the parents to be a good caregiver to the dependent and vulnerable child from the attacks coming from their own psychotic part.

On the side of the child

Narracci continues that due to the immaturity of their psychic apparatus ('ego'), the child is not able to filter, discriminate and distinguish what belongs to himself from what does not come from himself, until the point that this suffering explodes and results in depersonalization (Bion, 1970).

The massive, affective projections can create a narcissistic trap for the child: the child fulfills a vital position in the mind of the parent, which makes him strong *inside* but weak *outside* the relationship with the parent.

This results in a vulnerability, described by Narracci (2008) as the progressive deterioration of those structures that integrate and manage the affective and cognitive functions. With time, this results in replacing affective functions with a system of pathological and pathogenic identifications which parents and children are equally involved.

Reciprocal interdependency

Garcia Badaracco describes this interdependency where both parent and child are concerned, they are co-authors of a pathological situation. The parents' behavior keeps alive the symptomatology of their child, and the child forces their parents into the equally impossible position of not being able to free themselves from carrying out the function of nursing someone who does not want to be helped.

He understands the interdependency relation as a continuum, with on one side the healthy, reciprocal interdependence that generates resources of the Ego and a consistent identity, and with on the other hand a pathogenic interdependence, generating confusion, hallucinations or delusions.

In this way, pathology can be formulated and understood as the different modalities of the familial presence in the individual unconscious, or as the different forms of the presence of the others in us.

As such, a psychotic crisis brings the whole family in crisis: the natural equilibrium is disturbed. This leads to an invitation to the whole family to be involved in the recovery of the psychosis. Hereby the focus does not exclusively lies on the psychotic person, but on the psychological well-being of all family members, and the relationships between them.

By integrating an environmental aspect into the etiology, one could think that this means blaming the parents. Therefor an important note on 'guilt' is useful. Rather than 'blaming', we formulate an invitation to the family members to reflect on their own mental suffering and pain that could have been projected into their child. This is fragile and delicate way of thinking. As Narracci (2008) indicates, often it is not difficult to explain to the patient how his behavior influences the quality of life of the parents. But it is far less easy to create a therapeutic situation in which a parent can consider that his own difficulties have had an influence on the way in which the child's pathology has developed.

In this context the question of guilt often appears. This can be experienced by the parents as very scary and threatening for their own mental health. Martindale (2008) differentiates three different forms of guilt that can be expierenced:

- Projected guilt: feelings of guilt are evacuated in a massive way. The other is deemed responsible and is criticisized and attacked.
- Punitive, obsessieve guilt: the person is either punishing himself or is anticipating retribution for whatever he thinks he is doing wrong.
- Reparative guilt: there is concern for the other who is hurt. Restoration of the harm is the primary aim. Love and gratitude characterise this kind of relationship.

Van Bouwel (2009) completes these forms with:

- Guilt as an omnipotent mechanism to cope with trauma: sense of guilt brings us into an active position and transforms us into much stronger people than we really are.

Instead of avoiding, minimalizing or on the contrary accentuating guilty feelings, we try to understand them within the interpersonal relationship, and 'working through guilt' (Van Bouwel). By sustaining the parents to explore and work through their painful feelings, reparative mechanisms and concern can be mobilised in a constructive way. They can move from an omnipotent, guilty bound to a 'good enough' bound. During this process the parental provision of ego-support to their child, as formulated by Winnicot, can be restored.

Background of Multi Family Therapy

From this relational perspective on psychosis, we think the MFG is a unique and precious technique. While reviewing the literature on MFT it became clear that in the last two decades there is a growing interest. The following resume doesn't pretend to be a complete summary of all the kinds of MFT, it only wants to highlight some initiatives and ideas that we found useful for the development of our multi-family group.

Peter Laqueur is generally accepted as the founding father of the multi-family group. Since 1951 he treated patients diagnosed with a schizophrenic disorder in the Creedmoor State Mental Hospital in New York. Dr. Laqueur noticed that the families of the patients, after the visiting hours, gathered at the hospital doors and he observed the need for them to interact and to discuss the difficulties they are facing. The idea came to formalize these contacts and the first multi-family group was born. Inspired by early systemic family theories such as the double bind theory, it evolved to 'a sheltered workshop in family communication'. Laqueur (1964) started from the idea that and I cite: 'family relationships in which the illness emerged, can and should be changed in order to hasten recovery'. In his view the main problem of the patient consists out of a conflict between the struggle to reach differentiation as an individual on the one hand, and the need for a symbiotic attachment to primary family objects on the other hand. Laqueur had the idea that a MFT is the perfect setting to address this conflict. Laqueur cites Boszormeny-Nagy by saying that 'simultaneous presence of original and transference family figures provides a setting for growth promoting diversification of meaningful relational opportunities' (1962).

Laqueur choose a homogenic, closed group consisting of five families and he left the choice of the topic to the participants. He observed that members learned indirectly from each other through analogy, indirect interpretation, mimicking and identification. Laqueur describes for the first time how during this process of indirect learning, therapists are confronted with less resistance than while using direct confrontation.

Laqueur was a source of inspiration for William Mc Farlane, who is probably the best-known author in the field of multi-family therapy. He organized multi-family groups for patients suffering from severe psychotic disorders. Mc Farlane stresses the biological component of psychotic disorders and the group is based on the therapeutic principles of the Expressed Emotion theories. From this viewpoint, and in contrast to Peter Laqueur, Mc Farlane emphasized that every family is a healthy family, unless the contrary has been proven.

The goals for Mc Farlane were to enlarge the social network of the families confronted with psychosis, to fight the stigma around this disease and, by educating the family about the symptoms of psychosis, to make the caregivers more tolerant for the patients, what has a positive effect on the affective climate in the family.

He organized first 3 joining sessions with singular families, an then an all day educational workshop during a weekend day. Part of the workshop was a MFG. The group consisted out of 5 to 8 families, including the index patient. Afterwards they met once every two weeks for the first year and every month in the second year. So they engaged themselves for two years. The group members themselves brought problems into the group. Each session had the same structure and a focus on problem solving.

So, in contrast to Laqueur, Mc Farlane had a strong protocol to the therapy and shifted the focus to educational sessions. The work of Mc Farlane inspired many others to adapt his idea to different populations and different settings.

Another initiative that we certainly want to mention is the Marlborough Family center in London. Dr. Eia Asen extensively documented the work with the so-called multi-problem families done there. Inspired by the structural family therapy of Minuchin and therapists of the Milanese school, such as Boscolo and Cechin, they integrated more concepts from systemic therapy in their MFG. They leave the position of the expert, elaborate the idea of decentralizing the therapist and try to make the families therapeutic for each other. Hereto they introduce new techniques and interventions, like circular questioning, the reflecting team and the fish bowl techniques.

The technique and use of a MFG is mainly developed and documented within the systemic tradition. At the same time, Jorge Garcia Badaracco, an Argentinian psychiatrist and psychoanalyst, developed during his 40 years of experience with severe psychotic patients the conception of a therapeutic community based on a multi-familial structure. He considers the psychotic person trapped in a pathological interdependency. Garcia Badaracco therefor believes that the MFG provides the best conditions for the resolution of this relational trap that prevents the psychological growth and independency of all persons involved.

Multi-Family Group - Therapeutic aims

In short, we describe the aim of the MFG to support and enlarge the capacity for holding and ego-development of both young adults as parents. In what follows, we will analyze these 5 main goals more in detail. Therefor we can rely on 4 sources: the lecture of Garcia Badaracco (2000), representing a psychoanalytical viewpoint, the lecture of Asen and Scholz (2010), representing a systemic perspective, three interviews with participating parents by a independent researcher, and from our own experience as therapists.

To offer a place for **fellow sufferers**.

Garcia Badaracco states that the first function of the group is a place of encounter. There is a great need to meet other parents that are in the same situation. People encountering severe psychological problems might get isolated as a consequence of the idea that they, or their close relative, are different or abnormal. Sharing stories concerning these phenomena can make them feel connected and human again.

Asen and Scholz also accentuate the importance of creating solidarity ("*We're all in the same boat"*), and overcoming stigmatization and social isolation (*"We are not the only ones with these problems"*).

The interviewed parents underline this goal, finding in the MFG a place where they can freely talk about their experiences and feelings. Often it is one of the few places where they can talk about the psychosis of their child and find some social support, experiencing a large stigma with friends, family, or even within the partner relationship. Nevertheless, they are very sensitive of the impact of the stories. On one hand of the meaning of their own story to others ('*Is my situation not too well-going and confronting for other parents?', 'Does my situation doesn't frighten the others?')*, on the other hand the impact of the stories of the others from themselves ('*Can this also happen to us?').* This sensitivity indicates the importance of the homogeneity versus heterogeneity of the group, what we will discuss more profoundly later on. For example, a mother suggests: 'My daughter was internalized by force, this was very traumatic for all of us, and I speak a lot about this in the group. But maybe this frightens others who doesn't have this forced experience.' On the other hand, she adds: 'By speaking about this, another mother told how her generalist took a central place in directing her child to care, this opened my view.'

For us as therapists the encounter with fellow sufferers was a basic aim. In individual family sessions, we often hear the solitude and shame of the family. This can be so strong, that even participation in the MFG is not thinkable. This indicates the importance of a good welcome and of creating a secure place.

To offer a **secure place** for **emotional expression**.

Garcia Badaracco points out that despite the great suffering and the demand for help, there are many factors that can interfere. Negative feelings and forces can have an inhibiting effect, such as shame, guilt, jalousie, hate, and aggression. That's why the first task of the therapists is to create a positive climate that sustains the reciprocal listening and solidarity.

Asen and Scholz formulate this need as promoting openness and increasing self-confidence trough public exchanges and interactions ("*Nobody is after us, we can open up*") and the accent on raising hope (*"light at the end of the tunnel-even for us").*

Garcia Badaracco suggest to do this by installing an atmosphere to speak freely, orientated towards the understanding of what is going on. He suggests to install a climate where emotional expression is positively welcomed, and a positive transfer towards the therapists is sustained. This therapeutic alliance can be generalized among the participants, and creates the possibility to fraternize around a common task. It gives the possibility of a positive use of group pressure *("We can't cop out").*

He understands the difficulty of the therapeutic alliance in connection with the problem of the resources of the Ego. The deficit of the Ego-resources makes it difficult to tolerate the augmentation of great emotional charges. The therapist needs to provide a specific assistance of the Ego that is confronted with the obligation of being aware of contents that are difficult to think. This support consists in understanding and explaining the positive functions of what is at stake in

the relation. Putting the positive accent is not an act of kindness, but a necessary assistance of the Ego of every participant.

In this way a positive transfer and therapeutic alliance are indispensable to create the right emotional climate, adequate to contain and create new emotional experiences in the group. And it is by this emotional experience at the moment itself that thinking becomes possible, as Asen and Scholz say it: *"It's like a hothouse, things happen here".*

The parents indicate that they feel a large openness to talk freely, but that the common task of the group is not always very clear. Firstly, because the participants come with very different expectations. Secondly, the therapists don't formulate a clear aim of the sessions. Thirdly, the group composition changes every time due to the open character of the group, by consequence every session starts with the introduction of the new participants. This is experienced as helpful, but it slows down the possibility to work in depth on certain themes.

As therapists we accord with these remarks. We understand our caution to formulate a clear common task from the open, searching perspective on the contents and methods that we wanted to keep. But we also feel the need to impose more boundaries on the therapeutic task of the group, resulting in new ideas about how running the group, as will be presented later on.

A save place **to act out** the interdepency relation between child-parent

Our nuclear family is the social context in which we are born and have grown psychologically, and consists out of the interdependencies where we are kept in all our lives. These interdependencies often stay latent, but in the MFG things show themselves as there are, at place, direct, in vivo.

(Underlying conflicts, interdependencies and fantasmatic destructivity repeat themselves in the present, and in the presence of a multiple and diverse public of other participants. Once a family dares to show his particular problems, with often-longtime suppressed and hidden violence, this is an emotional experience where all the participants go through by identification.

Garcia Badaracco describes how this experience is often very painful, and the fear of breakdown tends to hold the rigidity of the known defenses. But if the MFG is a sufficiently safe and secure place, with clear and holding boundaries, he has the capacity to contain the violence that is so complicated and difficult to access. This experience 'opens' the pathogenic interdependency that gave a false feeling of security. The process of desidentification, experienced as a profound depersonalization, is then not destructive, but on the contrary, it can reinforce new authentic resources of the Ego, the experience of a real Self, that can develop to emotional intelligence.)

In the MFG there are many therapeutic resources available by the multiplicity of the identificatory field. By working through the immature aspects of the interdependency between a patient and his relatives in one family, the other participants profit in an indirect way. By witnessing and observing another family, one can understand the own situation differently, and perceive it as reversible and open. He will use not only the Ego-resources of the therapist, but also these of all other members in a constructive manner.

Asen and Scholz discriminate the following factors:

The shared, mutual support and feedback of the other participants (*"Terrific how you do this! And how do you think we're doing it?"*)

Stimulating new perspectives. (“I can see clearly these things in them for which, when it comes to us, I’m blind.)

Learning from each other. (*“I like the way others manage this.”*)

Being mirrored in others. (“We do this just like you.”)

Experimenting with Foster families and swapping. (*“We can manage other kids and I like the way other parents deal with my child”*).

The parents who were interviewed didn’t have an experience with their own son or daughter participating the group. They all think that if their child would participate as family, this would result in difficult sessions, tension, maybe overt discussions. In that way, they prefer to have a parent group, rather than a family group. Otherwise, they all found it very enriching when another young adult is present, to hear their experiences and how they handle the psychosis. It indicates the manifest need of the family to have information about psychosis, rather than seeing the group as a place to work relational issues through.

As therapists, it was one of our main goals in setting up the MFG to create a family group, where parents and young adults could interact. We present a short experience in this sense: A daughter was talking about the guilt experienced after her relapse. She was angry at herself concerning the lack of self care prior to the second episode. A father, not hers, reacted very emotional on this testimony. In his idea it was inappropriate to talk about guilt in the context of psychosis. The father emphasised the biological aspects of psychosis, the vulnerability for psychosis that is different in every individual. This reaction caused a heavy reaction in the daughter, who stated that if she cannot feel any guilt, that would mean that she cannot have any influence on her situation. The girl was trying to get out of this helpless position and to regain influence on her situation. This kind of discussion was only possible in the presence of two generations. We will discuss the difficulties about this topic later on.

To activate the potential for **creativity and change** in the interdependent relations.

Garcia Badaracco aims to create the necessary conditions and climate to make possible for every participant to think that what he can’t think by himself. As container the MFG offers a context to make possible the creation of a psychological atmosphere that facilitate the capacity to think, the resolution of conflicts and of reciprocal learning.

As Asen and Scholz puts it, the MFG offers a therapeutic resource to practice new behaviors in a safe context (*“We can experiment here, even if things go wrong some times.”)* and to discover and build up competences *(“I can do more than I thought. I am not completely helpless”).* This favorites the psycho-emotional development and growth.

The parents interviewed indicate that the MFG changed their relationship with their child. Not by the experiences in the group itself, in vivo, because as mentioned earlier: their child never participated. But at home, they understood and listened differently to the behavior of their child. For example: A mother says that she understand the psychotic crisis as a second chance in the relation with her son. This was a real eye opener for many other parents, who – often by guilt and fear – thought that they had done something wrong, and they were not capable to help their child. In the following session, a mother testifies how she had reacted with more calm and understanding to a difficult comment of her son.

As therapists we stay rather uncertain about the achievement of this goal. Starting from the idea to work through the relations in vivo, we were rather critical of the possible effects of a parent group. But in meanwhile we understand that the containing effect of the group can help the parents to enlarge their perspectives on what is going on, and to experience enough ego-strength to think and react differently in the relationships with their child.

To counter anti-therapeutic reactions.

Garcia Badaracco indicates that the potential of the group depends of the way of functioning of the composing persons, their productive capacity and creativity. Some stimulate the creativity of others, some suppress the openness by compulsive interventions through imposing their manner of thinking. Their attitude can downgrade other thoughts, and exercise an unconsciously influence that undermines the healthy potential.

The underlying reason is that the patient and his relatives are specialists in no-change. Painful themes often stay cleavaged, hidden or masked unconsciously, by the powerful mechanisms of defense maintained by the false self.

We believe in the necessity of respecting these resistances, without coincide with them. Slowly we feel the prudent openness and possibility to be more reflective at a personal level with the parents. For example, a mother who asks herself if her way of education was maybe too severe. On the other hand, we are touched by a father who is very critical during every session: he criticizes the received care, he holds on to a very strict biological framework, he devaluates our attempts to open a thinking space – it is the same father that formerly said to the daughter to not experience guilt. Nevertheless, he comes almost every session. We often asked ourselves why he still comes, while we feel so meaningless to him. In the interview he says how every session is very stressful for him, how the fear of a relapse is very present, and how important information and knowing is to cope with this uncertainties.

We consider it important to wait patiently, and to be alert when an opening intervention can be made. The experience of Garcia Badaracco supports us, who describes the often long way to reveal and discover the real nature of the pathogenic interdependencies. The MFG creates a context wherein during a long time other participants can give a number of micro-experiences that are emotionally corrective.

Caracteristics of our MFG

In this last part we will present the characteristics of our multi-family group, the decision making process and the rationale of the choices made.

Formal aspects

Concerning the formal aspects of our group: the group runs with sessions once every three weeks, and a break during summer holiday. The group take place at the ambulatory office in the city center. When the participants arrive, they're welcomed with coffee and tea and we take our time to be seated in a classical formation: all in a circle where therapists are mixed with the participants. The group is ran by two therapists. Other team members are invited and welcome, but participate on irregular basis. We open the session with an invitation to new participants to present themselves. Often this results in telling the story of the psychosis and the formulation of uncertainties and doubts the parents are confronted with this offers the basis for exchange of similar feelings, experiences and doubts with other participants.

Family or parent group

Our goal is a family group, where at least two generations are present. This comes from the main goal to create a secure place to work in the parent-child relation in vivo. But we note that this aim isn't that evident, because on the one hand parents have a large need to talk freely about psychosis without the presence of their child, and on the other hand the young adults don't have the need to come to the family group. Although we repeat the invitation to bring their own children, the most gatherings are among parents. This results a shift in our therapeutic task.

When a *son or daughter is present*, we pay a lot of attention to them. Often other parents are very interested by their story, and how he deals with his psychosis and the recovery. This makes that the adolescent often feels very supported by the other parents. As therapist we try to understand the psychotic experience in relation with the developmental tasks and position in the family. Exceptionally the young adult brings in relational issues with the own parents, what results in vivid interactions that we support.

When the group consists *only out of parents*, we experience a different function as therapist. Instead of working with the relationship between parent and child, we work with the parental capacity to understand their child. Parents have a large need of telling the story of their child in crisis, learning more about psychosis, having a place to talk about their experience as parent, learning how they can react on the crisis and recovery, helping other parents.

Directive versus non-directive position of the therapist

From the above therapeutic aims, we understood well that as therapist our function consists out of creating and securing the talking space. Hereto we take the position of a 'third', a moderator, without identifying with the knowing/expert position. As such, we choose not to introduce certain themes or methods. We try to connect families, by inviting them to talk, asking questions, relating certain themes or to put accent on differences in the experiences. By doing so we try to stimulate that all participants think, search and wonder, and help others to think. Our hope is that the participation of everyone results the discovery of a personal potential that isn't realized not yet, that the Ego-resources of some enrich the Ego of others, resulting in psychological growth.

This position was put under pressure several times by the compelling demand of the parents for more information, thereby considering us to be experts. By not taking this position parents experienced us as frustrating ('*you have the knowledge, but you don't want to share it with us'*).

By listening more closely to the needs of the parents, we became more conscious about the particular situation of the parents with a psychotic adolescent at home. They are parent and caregiver at the same time. We understood that it was necessary to give more psychological handles, not by being the 'knowing expert', but by containing the doubts, questions and uncertainties about their parent role. We try to strengthen their intuitions and free thoughts about their child and themselves. We try to help the parents to give meaning to the crisis in the personal history of their child and in the family development. In this way, we understand our role as "holder of the containment function"

To further meet this needs, we also decided to invite extern experts to our meetings. As such, we invited a person with lived experience to present his film, and to organize a psycho-educational session by Dr. Van Bouwel from the first episode ward. Doing so, we could stay in the moderating position and accompany the participants in the confrontation with new perspectives and theories about psychosis.

Open versus closed group

In many ways the option of a closed group is attractive. It's probably easier to set a therapeutic atmosphere where the participants feel safe enough to let go some of their defense mechanisms. In a closed group the participants are more likely to be in a same stage of the process. Although these benefits, there are also concerns that have leaded us to the option of an open group. An open group also stays an open invitation, without obligations, in this way we wanted to be as accessible as possible. This resulted in the choice for an open group where young adults, parents, brothers and sisters, partners, or other important relatives are welcome. There is no fixed number or finite agreement of participation, there is the idea of infinitive possibility of participation.

Homogeneous or heterogeneous group

Our focus lies on 'first episode' patients (cfr. staging model Mc Gorry), regardless the hospitalization of the adolescent. This gives a homogeneous group concerning the traumatic and ununderstandable nature of what happens. Mostly there is/was a good or high level of functioning of the son or daughter and the family before the psychosis, and comes the psychosis very unexpected.

But this results in a heterogeneity concerning:

- The triggers: drugs, travelling, start university, relationship break-up.
- The moment in the psychosis: in crisis, in early recovery, in retaking tasks of life.
- The context of recovery: at home, at the hospital, in forced care.
- The kind of psychosis: active symptoms (hallucinations or illusions), melancholia, bipolarity.

As stated before, parents experience this diversity of situations with a certain ambiguity. They all want to hear as many as stories as possible; to look for resemblances to their own situation. But these differences are also frightening, frustrating and confusing in their search for thé knowledge about psychosis.

To conclude

We hope we have gave an idea about what a multi-family group can be. We have formulated many ideas, shared some experiences, and leave many questions open.

D) ITALY

D.I The impact of Multifamily Psychoanalysis in Italy

We started using the Multifamily Psychoanalysis Group (MFPG) in the autumn of 1997, at the Tarsia Therapeutic Community of ASL Roma A, two months after it had opened. Five months earlier we had met Jorge García Badaracco at the presentation of his book: 'La Comunità Terapeutica a struttura multifamiliare' (the multifamily therapeutic community), presented by Dr Anna Nicolò.

At first we thought it would be a way of creating a collaborative atmosphere with the families of the patients treated in the Therapeutic Community (TC).

Within two months, my collaborators and I realised that the MFPG acted as a 'container' for all the events, both those we understood and those that remained unclear, that took place in the TC.

On the one hand, the MFPG helped us to understand the problems that existed in the relationship between the patients and their respective families, which the patients inevitably brought up in their relationship with the TC operators; on the other hand, it highlighted the difficulties and misunderstandings that occurred between the operators, which we were finally able to talk about more and sometimes resolve.

It was immediately clear that the MFPG had a fundamental impact on both fronts: on the one hand, in understanding how things were going in each family and how to try to make them less bad, and on the other, in managing the relationships between the staff working in a TC, which is equally important in achieving improvement for patients and their families.

Our awareness of the importance of managing the development of these two aspects was the basis for our comparison with Jorge García Badaracco three years later.

We were fortunate to have met an "extraordinary travel companion". At the time we met him, in March 2000, he had just published his third book, "Multifamily Psychoanalysis", in which he explained to us that this type of group could be run in any type of mental health service, not only in the TC, where patients stay for treatment periods of around two years, but also in mental health centres (CSM) and local day centres (DC), and in hospital wards where acute patients are admitted.In this context, he suggested that from 2000 onwards the groups should be called Multifamily Psychoanalysis Groups (MFPG).

Since then, we have worked to introduce the same type of treatment as in the TC to the two CSMs and the DC of ASL Roma A. At the same time, we have tried to make this way of working known to the operators of other health centres, both in our city and in the rest of the national territory, especially to the operators of other private and public TCs.

MFPGs began to spread, first in Rome and then in several Italian cities, large ones such as Naples, Cagliari, Turin, Milan, Catania, Florence, Perugia, Trieste and small ones such as Caltagirone, Morlupo, Sarno, Varazze, etc. etc.

Significant experience has been gained not only from the work of García Badaracco, but also from that of Enrique Pichon Riviere and Armando Bauleo: for example, in the Marche region, first in Macerata and then in Ancona, MFPGs were organised by the Public Service under the influence of all three authors.

The implementation of the MFPG can change the climate within any service, on the one hand because the relationship with both severe psychiatric patients and their families becomes less

conflictual and more collaborative, and on the other because it is possible to build a relationship of greater cooperation between all types of operators working in psychiatry, regardless of the schools that psychiatrists and psychologists have attended and the specific individual professional training.

The implementation of the MFPG in each of the services that make up a DSM (mental health department) allows an intervention to be carried out that is the sum of the interventions carried out by each service according to its specificity: a true departmental intervention. From this point of view, the most important experiences are currently taking place in Cagliari, in the DSM, in many centres in Liguria, in the CTs belonging to the Redancia Group, and in Sicily, both in the TCs and in the Public Service network.

In Rome, there are currently experiences involving whole Complex Operational Units (UOC) in the ASL Roma 1, in the 3rd and 13th districts. Innovative experiences are underway both in ASL Roma 2, where operators from the Mental Health Protection and Rehabilitation of Developmental Ages (MHPRDA) and from DSM jointly run an MFPG, and in ASL Roma 1, where an MFPG is run for patients aged 14 to 25 with psychiatric disorders and addictions and their families.

In 2012, LIPsiM (Laboratorio Italiano di Psicoanalisi Multifamiliare) was founded in Rome, a cultural association dedicated to the development and dissemination of Jorge García Badaracco's ideas, within which a two-year Master's Degree in Multifamily Psychoanalysis was organised.

The purpose of this association is to make known and transmit the work and thought of García Badaracco, who was generous like few others in making his knowledge and work experience available to all who were interested. He gave us a real training, involving us for over ten years, which radically changed how we approached and dealt with serious mental illness. Let's not forget that García Badaracco was for a long time the reference point for the International Psychoanalytical Association (IPA) on the problem of “psychosis".

We therefore felt obliged to extend the privilege we had been given to as many people as possible. The Master's Degree Course for 'Conductors' and, more recently, the Training Course for 'Facilitators' are our attempts in this direction.

D.II- The main concepts of Multifamily Psychoanalysis

Andrea Narracci, Alessandro Antonucci

The impact of the innovations introduced by Jorge García Badaracco is, in our opinion, very relevant.

We decided to limit to six the essential elements to be considered in order to try to delineate an overall picture of the theoretical points of reference of the Multifamily Psychoanalysis (PM). Working, we realized the impossibility of separating distinctly from each other, vice versa, it seems quite clear that they form a unique speech.

Elements one and two: parent and child

We believe that the first concept from which to start consists of what is explained, since the title, in the article published in the International Journal of Psychoanalysis in 1986, entitled The identifications and their vicissitudes: the object that drives you crazy. In this article, in fact, the

author expresses the conviction that the most serious mental illness, schizophrenia, which at that time, as today, represents 70% of serious psychiatric diseases, as well as mood disorders, as well as severe personality disorders and addictions, are determined not by something starting to malfunction, by birth or shortly after, within a person, for all the set of reasons on an organic basis that throughout the history of psychiatry have been hypothesized, particular type of relationship between two people. He also assumes that the object, that is one of the two parents, "drives the other crazy", that is, it performs a transitive function, contrary to what, until that moment, had been its statute.

We think that this is the opening of a new epistemology that outlines, with clarity, that can no longer be considered facts that seem to confirm such assumptions:

1. The child's suffering arises in the problematic relationship between a parent and a child, which the other parent either supports or does not do enough to prevent it from happening;
2. The parent-child relationship, which is supposed to contribute to the development of the child and the parent, fails to follow the planned path, marked by the need to progressively determine a process of separation between the two, with the consequent identification of the child and the parent; conversely, it freezes, as if, for both, it was not possible to separate from each other;
3. The parent is unable to let the child go away on his own because he has a symbiotic relationship with him, in which even though he is not conscious of it, he treats him as a part of himself, while the child adapts to live in this situation, to be one with the parent in question, as if this were the only way in which he thought he could live;
4. The parent, as clinically found in the groups of multifamily psychoanalysis (MFPG), has experienced a loss or trauma that cannot be processed and, therefore, first split and then disassociated, of which therefore loses the possibility of having a memory through the usual forms of activation of memory; as for the child, it is rather difficult for him, not to say impossible, to think that he can live in another way than in what is proposed by the parent to whom he feels more attached and, therefore, adapts to live according to the expectations of the latter, renouncing, without realizing it, to the search of other possible constitutive sources of one's own personality, as it happens for small children in general, who take a little bit of here and a little bit beyond and, progressively, assemble their own personality in an authentical way;
5. The state of things that is to be determined: the symbiosis between the parent and the child, cracks when the child, in adolescence, meets experiences that allow him to feel that there are aspects of his personality that he did not know he had and that, on the contrary, they seem to him more his own than those he had experienced up to that moment, linked to the relationship with the parent with whom he shares the symbiotic state;
6. At that point you may either feel you have the abilities to 28 live-compete with your peers and begins to relentlessly close in on yourself, or you face a personality break, in the sense that, experiencing the irreconcilability between the two parts of the personality with which he came into contact, the previous one, modeled on the expectations of the parent and the most recent one, related to aspects more corresponding to his Self, but completely incompatible with the former, at some point he dissociates himself and has an acute psychotic crisis;
7. At that point, the symbiotic parent, together with the other parent, would like the child to return to what he was, while the child cannot give up the possible novelties concerning

him; In addition, he is diagnosed sick with an incurable disease to which he must resign himself to remain subjected to throughout his life, as well as taking drugs that can make him feel less sick, on the one hand, but also that generally make it harder to recover. In a nutshell, his suffering is read as a disease that concerns him and his organic substratum, while the aspects related to the evolution of the most significant relationships for him do not seem to be taken into account;

8. Which, on the other hand, can happen if the parent and child, together with the other parent and any one or more other children, begin to participate in a PM group and realize that it does not all depend on the patient, but on him and the parent to whom he is most attached, which between them the symbiotic bond has become, with time, a pathological and pathogenic interdependence which, however, contrary to what psychiatry, not dealing with it, implicitly believes that it is not chargeable, can be understood that it exists and that it is not unchangeable.

Element three: "Healthy Virtuality"

As mentioned in point one, if the parent and child bound by the link of pathological and pathogenic interdependence begin to attend the MFPG, may have the possibility to recognize the existence of the type of bond in which they are involved and realize that it is necessary for this bond to subside if they want to begin to live their own life, less bound or even detached from that of the other.

Participation in the MFPG can take place together with the rest of the family or, in any case, even only by themselves or, at least, one of them, so that each member of the family always carries his own "internal family"; regardless of whether other family members participate or not, the links within a family can be evoked by the presence of the other participants in the group, even 29 in the concrete absence of the other family members.

Once the difficulty of resuming one's growth path is recognized in relation to the cumbersome presence of the original symbiotic bond, which has transformed into a "pathological and pathogenic interdependence"They both begin to realize that only by attenuating the existence of this bond will everyone have a chance to start living their own lives.

If, by participating in the MFPG, this becomes possible, everyone will have the opportunity to begin to know the traits of their healthy virtuality, that is, to realize that there are large spaces of the Self that, on the part of everyone, have never been expressed, as regards the child or have not been expressed any more, as regards the parent. On the other hand, once the link of pathological and pathogenic interdependence is attenuated, it becomes possible for each of them to begin exploring parts of themselves that they did not know they had or that they had forgotten to own.

The concept of healthy virtuality corresponds to a state of Self that neither of the two, in the previous situation had the opportunity to experience. It is as if it were something whose existence cannot be recognized as long as people are in the previous situation and which can begin to be focused only to the extent that the pathological link is attenuated and tends to be reduced.

Of that bond, once experienced, it seems very difficult to do without, unless both are able to prove, mutually, that everyone can do it alone, on their own.

The symbiotic bond does not allow replicas: people remain inextricably linked and will tend to continue to worry about each other, rather before the other than themselves, in the first instance.

They must always keep in mind that they have little pronounced boundaries of the Self, with respect to the other, and that, before realizing it, everyone can come to worry about the other instead of himself.

In relation to this, exploring your healthy virtuality can be very difficult. You can give up the first difficulty you encounter and go back to putting concern for the other before concern for yourself.

Therefore it is necessary to remain very vigli and not to forget to bring with itself this terrible kit.

Nevertheless, the discovery of one's own healthy virtuality can be an extraordinary and moving operation. It's about the ability to give yourself the right to do it, to be able to look after yourself before any other person.

It may seem an easy operation but for those accustomed to hearing the problems of the other not separated from their own, indeed to constitute a whole not diversified among them, it can be very difficult.

From the stories of the patients and the parents and the bonds they lived, it emerges clearly that any difficulty experienced by the other was not considered of the other, but was treated as if it were their own. This is the starting point from which to look forward, not the other way around.

Healthy virtuality can seem fascinating, but also very difficult, and it can be much easier to turn around and go back to being confused and also not feeling the weight of the responsibility of your life, that can exert a diabolical charm in people's lives, but also a lot of fear.

Finally, we must keep in mind that time for a long time is as if it had not passed and that people are immersed in the same atmosphere that they have shared, in the true sense of the word, for a long time. One of the most striking features of the symbiotic relationship is that it must remain unchanged, therefore it interrupts the possibility of the transformation of the bond and ends up doing without the evolution of time.

We believe that time does not pass in psychosis, precisely because the patient child and the parent live a bond that must remain unchangeable. If time does not pass, the moment of separation cannot occur. Therefore, remaining motionless is a bit like being protected from the danger that things can change. If they stay the same, they won't change. To live the experience of change from having experienced such a situation for a long time is extremely difficult. This is precisely why Jorge García Badaracco considered psychotic specialists in non change.

Element four: the rules of operation, the mechanisms at work, the Atheneo and relations with the usual forms of psychotherapy

The group of multifamily psychoanalysis, for its development, is characterized by the need to refer to three general rules of behavior. They are asked to conform to all participants in the group.

They are:

1. The word is attributed to one person at a time and all other persons present are required to listen carefully to what is being said; action can be taken only after the person has completed his or her intervention; everyone is required to realize that he can keep his word for a limited time 31, so as to allow all those who want to intervene;
2. Everyone is asked to "not claim to be right", that is to learn to tolerate that another person can express an idea profoundly different from his own, whoever he is and that this event

should be seen not as a iattura, but as a possible novelty, which should not be refused and/or countered;
3. Interventions, as far as possible, should be booked, as in an assembly, so that there is an order respectful of the presence of the other, with the hope that a way of functioning of the group itself, which Jorge García Badaracco defined as "broad-minded"in relation to which the individual interventions acquire, unknowingly by those who utter them, the ability to add to each other, rather than to oppose each other, thus giving rise to a single overall thought of the group of that particular day.

During the MFPG there are three modes of operation of the group itself, defined by me as "mechanisms", characteristic of this type of group, consisting of many families and individual individuals who, however, come to the group with their "internal family".

They shall consist of:

1. From the "metaphorical mirroring", that is, from the possibility that each present has to observe, from the outside, what happens in another pathological family unit, different, but not so far, in the way it works, from its own. This can only be observed in this type of group;
2. The reacquisition of the ability to represent, which is not lost but temporarily unused, in psychotic families, partly because it is believed to be the only ones to live that dramatic experience of which, fundamentally, we are ashamed; partly because you are too busy to answer on the "concrete", that is, on a single plane; in part, finally, because being able to do so could mean being able to "metacommunicate" on the situation in which you live, which is the only way to change it that, usually, does not happen.
3. The so-called "multiple transferences", that is, the fact that a multitude of transferences can be established in the MFPG, a phenomenon discovered by Freud with psychoanalysis but spontaneously present in nature, for example, between a child and the parents of another nucleus and vice versa, or between a parent and another parent, belonging to two different nuclei, etc. This phenomenon makes possible the occurrence of such a group and the establishment, in particular, within it, of an atmosphere in which they are present in meaningful form- 32 reduced those phenomena of psychotic anxiety, linked to the establishment of psychotic transference that, typically, occur in individual psychoanalytic psychotherapies of severe patients, in family therapies of individual families, etc.

On the other hand, the MFPG must be thought of as a useful device to make accessible the use of thought in situations where this encounters at first sight insurmountable difficulties and ends up speaking more through acts than through words.

In this sense, it is a device that can make it less complicated than the use of both individual and group interventions for analytically oriented severe patients, as well as for the single family unit.

The use of the various usual forms of psychotherapy is one of the objectives that the group proposes, precisely in order to construct modes of intervention - the group of multifamily psychoanalysis - on the one hand, and one or more forms of traditional psychotherapy, on the other hand, that they reinforce each other in the difficult task of combating severe mental illness.

Together with the group, or rather as an integral part of it, it should be thought, finally, the meeting reserved for operators that is held regularly at the end of each group, lasting half an hour-an hour or more, called "Atheneo". It is a group in which it is possible, on the one hand, to resume the clinical steps that have appeared among the most significant among those that have

manifested themselves in the group just ended, on the other hand, to allow operators who have suffered the influence of the group, like the others, to reflect on how they have been and, above all, whether the participation in the group itself has produced the possibility of recovering, also from each of them, split and kept dissociated aspects and, therefore not recoverable habitually, concerning themselves.

This can be configured as a continuing training program to which operators submit themselves.

Element five: the "Broad Mind"

As for the operation of the MFPG, we have described the third mechanism, which is established if we have the patience and perseverance to ask those present to intervene by booking their intervention.

By proceeding in this way, a particular effect is obtained: gradually we realize that the interventions that follow one another tend to integrate each other to form a single large intervention, made up of all the interventions of those present, even if they were conceived as individual interventions by each person and were born as representative of the desire to express themselves of each of the people who intervened.

In this sense it is a great mind at work, made up of the minds of all those present who work in connection.

We believe that this type of experience is very important for those who participate in the MFPG, In general, he comes to the group with a concept of how the different points of view of each of the participants can relate to each other practically inversely to that experienced in the "broad mind" operation. And, that is, with the idea that one's own opinion cannot avoid colliding with the opinion of the other and that it is basically about trying to make one's own point of view prevail over that of the other. To discover, by participating in the group, that one's own opinion can be integrated and not opposed and, together with the others, give rise to a sort of common thought that contains the thoughts of all those who have expressed themselves, is an experience absolutely antithetical to those habitually experienced within their families to psychotic transaction, in which, vice versa, everyone tries to prevail with their own opinion against that of the other: there are no longer messages of content, but only those of defining the relationship. Consequently, there is no more listening, no more respect.

On the contrary, in this type of group is proposed the idea that it is possible and useful to listen to the other, that must be respected and, finally, realize that if you let go, you find yourself building together with others a thought that represents us all, from which the insurmountable divisions from which one had departed disappeared.

Then there is another phenomenon, perhaps even more important. Following the third rule which proposes the need to book before intervening, the time between the request for intervention and the moment when the word is given to intervene, the things that those who had raised their hand had in mind to say are mixed with what was said by those who had preceded him.

The introduction of this mode of regulation of the progressive order of interventions makes it possible that the habitual, mainly rational, secondary-type functioning of the minds of the participants, is also combined with the primary functioning of free associations.

We believe that this phenomenon makes possible something particularly important in these groups: that elements that are split and dissociated and, therefore, present but not usable by the minds of those present, become accessible.

With this type of pathologies this opportunity opens the possibility of being able to shed light on aspects otherwise destined to remain absolutely not approachable. I refer to what happened in the symbiotic relationship between a 34 parent and a child during the period in which the absence of any kind of boundary between the two allowed the indiscriminate perception of trauma or bereavement not processed by the adult even by the and that this perception happened without the latter having the possibility to realize that it belonged to the other and not to himself. I mean, the little one feels that pain like it's his own. After that the great spark and, dissociating it, makes the memory unattainable, while the small remains invested and continues to feel it confused as existing, while the great has lost the possibility of referring to it. We are talking about unconscious mechanisms, for which no kind of guilt or responsibility is discernible. This does not alter the fact that these facts can happen and produce consequences on the children, who then become sick, for example, expressing delusions that have a basis of truth but that, later, take unconnectable paths of expression. On the other hand, no serious patient knows why he is ill and no parent can help him unless he starts attending an MFPG and finds the strength to deal with aspects of his life that may suddenly emerge from a confused past. At that point, the parent can become the greatest ally of the son and of all present, looking for something that for the parent had dissolved but that can reappear and that for the son has always continued to be there, but in a form where it was not possible to make sense of it.

Element Six: The Effects of Using MFPG in Institutions

This is the story of an experience I gained in 2010, as director of the Mental Health Department (DSM) of the Local Health Authority (ASL) Roma1 (user area of 500,000 people). I thought it appropriate to introduce Multifamily Psychoanalysis Groups in ten of the eleven services present in the DSM. In the 1st District there were already three groups (one in the Therapeutic Community (CT) and two in the Mental Health Center (CSM) and in the Day Center (CD)), and I organized seven new groups in the other DSM services, in the Psychiatric Diagnosis and Treatment (SPDC) of the Sant'Andrea Hospital (hospital service for patients of the 4th District) and in the Therapeutic Community for young people aged 18 to 25 coming from the Service for adolescents and young adults. Only the Psychotherapy Service for Adolescents and Young Adults was excluded, which preferred to continue working with the classic method: seeing children individually and parents as a couple and/or in a group of parents only.

During the experience some facts happened that we will try to underline:

1. Within each service in which the Multifamily Psychoanalysis group was regularly carried out, the relationships between patients and family members and Service operators improved; the MFPG has, in fact, the ability to reconstruct or build for the first time a sufficient degree of "therapeutic alliance" between operators and families, including patients;
2. The service operators were able to feel, again or for the first time, that they could collaborate with the operators of their own service and of the "nearby" service;
3. It finally became possible to imagine an intervention project, imagined from the "first moves" and regardless of where the first request for intervention was made, as something

carried out by the DSM as a whole through a control room that planned the interventions between the various services involved;

4. The overall climate of the DSM was modified by the establishment of an intervention culture shared by a good part of the operators, used with curiosity, even if not fully shared by another good part of them and, by of a fairly small share of operators, not opposed but observed with greater perplexity or pseudo indifference.;
5. In relation to this, to improve this overall state which was not one of harmony, I decided to introduce a substantial change in the functioning of the DSM: the Department Committee, i.e. the body responsible for defining the guidelines of the DSM itself, was usually composed of by the heads of the Complex Operational Units, i.e. by the Heads and heads of each professional figure, and was generally met once a year. I decided to meet it once a month, for a total of about ten Committees a year, each time on one or more topics about which it was urgent to make decisions;
6. I also decided that any DSMC operator who deemed himself competent regarding the topic discussed on that occasion could participate and intervene in the monthly Department Committees, regardless of his qualification. Simply put, we established that most workers who routinely did not feel listened to could make their voices heard and begin to feel part of the decision-making processes that sought to determine the direction in which the DSM of which they were a part proceeded;
7. This decision contributed to the creation of a different climate within the DSM, in which each operator could no longer entrench himself in the position of "feeling excluded" from the decision-making processes and forced to delegate the decisions to be made to others, but rather placed in the conditions to deal with the possibility/necessity of taking on responsibilities and, if deemed appropriate, making decisions.

What we want to say is that the proposed and shared introduction of a MFPG within each service that makes up a DSM can significantly impact the specifically professional activities of the DSM, through the construction of a new culture of intervention towards serious mental pathologies which, first of all, the DSM is called upon to deal with, but also in terms of the functioning and, therefore, the organization of the decision-making bodies of the DSM itself.

We believe that it is very important to give the floor to patients, family members and operators in a situation, such as that of the MFPG, in which it is possible each time to re-negotiate the way in which we relate to each other, with the aim of uniting the strengths of these three fundamental components of Mental Health to improve the standard of living of people with serious mental disorders and their families.

We think that it is possible to modify institutions to the benefit of those who work within them, with the aim that those who are part of them do not continue to think of institutions as "invincible dragons" by which one can only be mistreated/massacred.

Institutions can have one character or another: they can be conceived to manage the power of a few against the many, or they can be experienced firsthand, through democratic functioning mechanisms, which are able to guarantee to all those who they are part of having a say in what needs to be decided.

BIBLIOGRAPHY

ANPAL (2023). *Rapporto Italiano di Referenziazione delle qualificazioni al Quadro Europeo EQF*, Ministero del Lavoro, Collana Biblioteca Anpal n.25.

ARGYRIS C. & SCHOUN D.A. (1978). *Organizational Learning: A Theory of Action Perspective*, Reading, Addison Wesley.

ASEN, E. & Scholz, M. (2010). *Multi-Family Therapy: Concepts and Techniques*, London, Routledge.

BANDURA, A. (1982). "Self-efficacy mechanism in human agency" in *American Psychologist*, 37(2), 122–147.

BANDURA, A. (1986). "The explanatory and predictive scope of self-efficacy theory" in *Journal of Social and Clinical Psychology*, 4: 3, 359-373. doi:10.1521/jscp.1986.4.3.359.

BANDURA, A. (2008). "Toward an agentic theory of the self" in H. Marsh, R. G. Craven & D. M. McInerney (Eds) *Advances in Self Research*, Vol. 3: Self-processes, learning, and enabling human potential. Charlotte, NC, Information Age Publishing.

BATSON, D., EARLY, S. & SALVARANI, G. (1997). "Perspective Taking: Imagining How Another Feels Versus Imaging How You Would Feel" in *Personality and Social Psychology Bulletin*, 25(7), 751-758.

BIALIK, M. & FADEL, C. (2015). *Competences for the 21st Century: What Should Students Learn?* Boston, Centre for Curriculum Redesign.

BION, W. R. (1970). *Attention and Interpretation*, London, Tavistock Publications.

BÖCKLER, A., HERRMANN, L., TRAUTWEIN, F. M., HOLMES, T. & SINGER, T. (2017). "Know Thy Selves: Learning to Understand Oneself Increases the Ability to Understand Others", in *Journal of Cognitive Enhancement*, 1, 197-209.

BOYATZIS, R., GOLEMAN, D. & MCKEE, A. (2002). Primal *Leadership: Realizing the Power of Emotional Intelligence*, Boston, Harvard Business School Press.

BOYATZIS, R.E., GOLEMAN, D. & HAY ACQUISITION (2001/2007). *Emotional and Social Competency Inventory (ESCI)*, Boston, MA, The Hay Group.

BRUNELLO, G. & SCHLOTTER, M. (2011). *Non-Cognitive Competences and Personality Traits: Labour Market Relevance and their Development in Education and Training Systems*, IZA DP No. 5743, Bonn, Institute for the Study of Labour.

CAENA, F. (2019). *Developing a European Framework for the Personal, Social & Learning to Learn Key Competence (LifeComp). Literature review and analysis of frameworks* (EUR 29855 EN), Publications Office of the European Union.

CAENA, F. (2019). *LifeComp Key Competence Framework. Personal, Social, Learning to Lear, Scoping Paper*, Joint Research Centre, European Commission.

Cambridge Framework of Life Competencies. Introductory Guide for teachers and Educational Managers, Cambridge, Cambridge University Press.

CARE, E. & LUO, R. (2016). *Assessment of Transversal Competencies. Policy and Practice in the Asia-Pacific Region*, Bangkok, Unesco.

CEFAI, C., BARTOLO, P., CAVIONI, V. & DOWNES, P. (2018). *Strengthening social and emotional education as a core curricular area across the EU. A review of the international evidence: analytical* report, European Commission, Neset II.

CENTENO, M.J., NETO, I.M. (2008) A multifamily group at a psychiatric day hospital – a group analytic experience, in Newsletter of the Group Analytic Society, London. "Contexts" –N.40 June 2008 p.35-40

CIBORRA C. & LANZARA G.F. (1988). "I labirinti dell'innovazione, routines organizzative e contesti formativi", in *Studi Organizzativi*, XIX, n. 2 pp 113-134.

DEMETRIOU, A. (2014). "Learning to learn, know and reason", in STRINGHER, C. DEAKIN, R. & Kai REN, K. (Ed.), *Learning to Learn: International perspectives from theory and practice*, 41-66, New York, Routledge.

EFKLIDES, A. (2006). "Metacognition and affect: what can metacognitive experiences tell us about the learning process?", in *Educational Research Review*, 1, 3-14.

EUROPEAN COMMISSION (2011) *Non Cognitive Competences and Personality Traits: Labour Market Relevance and their Development in E&T Systems,* Analytical Report for the European Commission prepared by the European Expert Network on Economics of Education (Eenee).

EUROPEAN UNION (2010) *New Competences for New Jobs: Action Now A report by the Expert Group* prepared for the European Commission.

EVRARD, G. & BERGSTEIN, R. (2016). *A Competence Model for Youth Workers to Work Internationally.* Bonn, SALTO Training and Cooperation.

FISHER, R., MARITZ, A. & LOBO, A. (2016). "Does Individual Resilience Influence Entrepreneurial Success?," in *Academy of Entrepreneurship Journal,* 22:2, 39-53.

FRANÇA DE SOUSA (2013). "Seminário Joao dos Santos: Na consulta de Psiquiatria do Hospital de Santa Maria" in https://joaodossantos.net/contributos/seminario-joao-dos-santos- na-consulta-de-psiquiatria-do-hospital-de-santa-maria/

GARCÍA BADARACCO J. (1986). "Identification and its vicissitudes in the psychoses. The importance of the concept of the 'maddening object'", in *The International Journal of Psycho- Analysis*, 67:133-146. 37.

GARCÍA BADARACCO, J. (1990). *Comunidad terapéutica Psicoanalítica de Estructura Multifamiliar*, Madrid, Tecnipublicaciones.

GARCÍA BADARACCO J. (1997) *La Comunità Psicoterapeutica Psicoanalitica di struttura multifamiliare*, Milano, Franco Angeli.

GARCÍA BADARACCO, J. (2000). *Psicoanálisis Multifamiliar, los otros en nosotros y el descubrimiento del sí mismo*, Buenos Aires, Editorial Paidós.

GARCÍA BADARACCO, J. (2000). *Psychanalyse multifamiliale: Les autres en nous et la découverte du vrai soi-même*, Paris, Editions in Press.

GARCÍA BADARACCO, J. (2000) *Psicoanalisi Multifamiliare*, Torino, Bollati Boringhieri 2004.

GARCÍA BADARACCO J.G. & NARRACCI A. (2011) *La Psicoanalisi Multifamiliare in Italia*, Torino, Antigone Edizioni.

GARCÌA BADARACCO J. (2018). *Seleccion de Trabajos, tres volumenes*. Comp. Maria Elisa Mitre. Buenos Aires, Editorial Asociaciòn Psicoanalitica Argentina y Editorial Antigua.

GARDNER, H. (1983). *Frames of Mind, The Theory of Multiples Intelligences*, New York, Basic Books.

GODINHO, P., DIAS, M. J. & MATOS, M. (2004), "Multifamily Groups at a Day Hospital. A two- years' experience", in Third European Conference of Psychoanalytic Group Psychotherapy "The Individual and the Group", Bridging the Gap, Ispa, Lisboa,7-10 oct.

GODINHO, P. CENTENO, M. J., FIALHO, T. & NETO, I. (2012). "El grupo multifamiliar y el síndrome de las puertas abiertas: del diagnóstico a la terapéutica. La contribución portuguesa", in *Teoria y Pratica Grupoanalítica*, 1(2) 123-136.

GODINHO, P. (2016). "Personalidades y Parentalidades. Contribuciones al enfoque de necesidades específicas de intervención en Psiquiatría y Salud Mental" in Rotenberg, E. (comp)

GODINHO, P.(2020). "El descubrimiento de García Badaracco: de la Psiquiatría a la Historia del Futuro", 289-299, in Mitre, M. E. *Diez años después: homenaje a GarcíaBadaracco.1*, ed. CABA : Ditem.

GOLEMAN, D. (1998). Working with Emotional Intelligence, *New York, NY Bantam Books.*

GUSTEIN, A. J. & SVIOKLA, G. (2018). "7 Competences that aren't about to be automated" in *Harvard Business Review*, July 7, 2018.

HANSEN, T. (2013). *The Generalist Approach to Conflict Resolution.* Plymouth, Lexington.

ISFOL, FELICE, A. & D'AGOSTINO L. (a cura di) (2013). *Le competenze trasversali nelle équipe della salute mentale*, Roma, Isfol, https://isfoloa.isfol.it/xmlui/handle/123456789/1403>

JONES, M. (1953). *The Therapeutic Community*, New York, Basic Books.

KIRSCHNER, P., KIRSCHNER, F., SWEKLLER, J. & ZAMBRANO R. J. (2018). "From Cognitive Load Theory to Collaborative Cognitive Load Theory" in *International Journal of Computer-Supported Collaborative Learning*, 13:2, 213-233.

LANZARA G.F. (1993). *Capacità negativa: competenza progettuale e modelli di intervento nelle organizzazioni*, Bologna, il Mulino.

LE BOTERF, G. (1990). *De la compètence: Essai sur un attracteur étrang*e, Paris, D'Organisation.

LE BOTERF, G. (1997). *Competence et navigation professionnelle*, Paris, D'Organisation.

LE BOTERF, G. (1998). *L'ingénieries des compétences*, Paris, D'Organisation.

LE BOTERF, G. (2002). "De quel concept de compétences avons-nous besoin?", in *Soins Cadre* n.41, 20-22.

LE BOTERF, G. (2008). *Costruire le competenze individuali e collettive*, Napoli, Guida.

LUCAS, R. (2009). *The Psychotic Wavelength A Psychoanalytic Perspective for Psychiatry*, London, Routledge.

MANSO NETO, I., FIALHO, T., GODINHO, P. & CENTENO, M. J. (2010). “Treating and Training: A 30 Year Experience of a Team with a Group-Analytic Framework: Part I. Group Analysis”, 43(1), 50–64. doi:10.1177/0533316409357133. Jane Abercrombie Prize.

MANSO NETO, I., FIALHO, T., GODINHO, P. & CENTENO, M. J. (2010). “Treating and Training: A 30 Year Experience of a Team with a Group-Analytic Framework: Part II. GroupAnalysis”, 43(2), 107-126. doi:10.1177/0533316410364727. Jane Abercrombie Prize.

MARTINDALE, B.V. (2008). “The rehabilitation of psychoanalysis and the family in psychosis: Recovering from blaming” in Gleeson J.F.M., Killackey, E. & Krstev, H. (eds.), *Psychotherapies for the Psychoses,* London and New York, Routledge.

MARUCCO, N. & MITRE M.E., Padres e hijos… el poder de enfermar al otro. Curar desde la vivencia, pp. 161-192, CABA, Lugar Editorial.

MASCARÓ MASRI, N. (2006). “La constitución de un GMF en una institución pública”, in Rev. *Avances en Salud Mental Relacional*, Vol. 5, n. 2.

McCLELLAND, D.C. (1973). “Testing for competence rather than intelligence”*,* in *American Psychologist Association*

McCLELLAND, D.C. (1998). “Identifying competencies with behavioral event interviews”, in *Sage Journals.*

MITRE, M.E. (2021). *Le voci del silenzio,* Roma, Giovanni Fioriti Editore.

NARRACCI, A. (2008). “La mia esperienza con il gruppo multifamiliare”, in *Interazioni*, 1: 51-73.

NARRACCI, A. RUSSO, F., ANTONUCCI, A. & MAONE, A. (2015). *Psicoanalisi Multifamiliare come esperanto*, Torino, Antigone Edizioni.

NARRACCI, A. a cura di (2021). Da oggetto di intervento a soggetto della propria trasformazione, Milano*, Bruno Mondadori.*

NETO, I. et al. Moving the Group work into the Day Hospital setting. In: Radcliffe, J., Hajek, K., Carson, J., & Manor, O. Psychological Group work with Acute Psychiatric Inpatients*. London: Whiting & Birch Ltd. Cap. 18, p. 325-338. (2010)*

OECD (2018a). “Future of Education and Competences: Conceptual Learning Framework. Draft concept note on construct analysis. Working Document for 8th Informal Working Group meeting”, Paris, 29-31 October 2018.

OECD (2019b). *OECD Future of Education and Competences 2030. Conceptual Learning Framework. Concept Note: Transformative Competencies for 2030*, Paris OECD.

Psychological Science, Vol. 9, 331-9.

Psychologist, Vol. 28 No. 1, 1-40.

RAWSON, M. (2000). “Learning to Learn: More than a competence set. Studies in Higher Education”, 25(2), 225-238.

RACAMIER, P.C. (2010). *L’inceste et l’Incestue*l Paris, Dunod, 174 p.

UNESCO (2013). *Intercultural Competences. Conceptual and Operational Framework,* Paris.

UNESCO (2015b). Transversal Competencies in Education Policy and Practice (Phase I). Asia-Pacific Education.

VAN BOUWEL, J. (2009). “Guilt as a reparative motor”. Personal communication on ISPS congress in Copenhagen, Juin 2009.

WIERSEMA, J. A., LICKLIDER, B., THOMPSON, J. R., HENDRICH, S., HAYNES, C. & THOMPSON, K. (2015). “Mindset about Intelligence and Meaningful and Mindful Effort: It’s Not My Hardest Class Any More!” in *Learning Communities Research and Practice, 3*(2), 1-17.