Good enough therapists

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Abstract
We are aware that the subject is born and develops in relation to others, both in case of an healthy functioning and in mental illness. From this perspective, the role of the therapist is not limited to his technical work, but also to his taking into account the needs of the patient and to succeeding, starting from this, to promote a new healthy mental development. Various factors of the personality of the therapist come to the fore when working with severe patients, such as the adequate transparency, the Multifamily psychoanalytic approach in this type of pathology in the context of co-therapy, an atmosphere of security, trust and closeness, with a constant objectivity that allows the psychic autonomy of the patient. These factors are essential to carry out a positive treatment.

Keywords: Group therapy, multifamily psychoanalysis, co-therapy, counter-transference, transference

If we consider the subject as an inseparable part of the group in which he was born and the social group to which he belongs, we understand that the Ego 'requires' the Other to take form and develop, both as a "self" and as a "self" considered in a relationship". It needs a relational plot to supports itself, which allows the acceptance and the impression a valid "Self".

Only from the experience of "belonging" to others, commensurate with the good-enough therapists, a process will take place of bond and relationships, bringing to the development of individuation, autonomy, and the experience of being in reciprocal connection.

From this perspective, a rethinking of the idea of psychic conflicts and of the role of the therapist should occur. In addition to the techniques, patients seriously need someone who takes charge of them in a more comprehensive way.

If the therapist works only at the service of a technique or a strategy, he will probably not consider what the patient really needs.

The whole discussion developed here makes sense only if we start from the idea that patients with serious mental illness can be cured if you offer them the necessary conditions for a new healthy mental development.

The patient needs us to believe in him as a human being and in his ability to change, and necessitates someone taking care of him to get to know the nature of his difficulties, which are overwhelming and invalidating him.

Maria Elisa Mitre differentiates the importance of the therapist's personality, his human qualities, his ability to relate to others; these issues are fundamental for the new healthy development of the patient.

Therapist’s personal qualities stand out, such as his freedom of expression, his spontaneity and the ability to put himself in the others’ shoes, and his authenticity.

There are doubts about the fact that the analytic work can be effective if a genuine human interest is replaced by "neutrality."

Behind every suffering human being there is a child who asks for help, with the need to be loved and recognized. The indifference or excessive neutrality may reactivate traumatic childhood frustrations. Multifamily psychoanalytic perspective considers the real family of the patient, that must be included in the therapy to accompany the process, allow the necessary changes, and implement, in turn, the family therapeutic process.

In this complicated work, for several reasons, we emphasize the need for co-therapy and working as a team.

The therapeutic team is one of the main agents of psychic change. For Schultz, says Badaracco, confidence that therapists have in themselves with respect to their work is an important tool to calm the patients’ doubts about themselves and the possibility of being cured.

It is a "sine qua non" elemental work for us to form "good-enough" teams, capable of assuming, as the "good-enough mother", the needs of the patients and avoid them carry the burden of our and their own difficulties.

A "good-enough doctor" (in Winnicott's sense) must work as a "container".

Winnicott took the image of the mother with the baby in her arms as an archetype, complementary with the Bion's concept of reverie. Doctor’s presence will be stable, available and not suffocating.

Severe patients, initially beyond verbal communication, seek the primary affect, a personal contact through a different and structuring climate which can support their weak Ego. They look for a real presence, not a projection screen of unconscious contents, which would be insufficient for a real psychic change. In the first stage of the therapeutic process, the patient mostly receives non-verbal rather than verbal communications; most important is how something is communicated rather than what is said. Only in a climate of psychological safety the patient will be able to develop a true Self. Patients can feel that they occupy a place in us; that we have pleasure meeting them; they will experience a chance to feel more alive, and explain the deepest experiences, anxieties and doubts with total freedom, allowing themselves to encounter their deepest parts.

According to Racamier and Nach, the presence of the other is the most important thing for the psychotic patient, but it is also very challenging. The dependence scares the patient because he lives the object as destructive and devouring, and the absence turns into loss and destruction.

Badaracco underlines how continuity has been a key therapeutic element allowing the psychotic patient build the constancy of an object relationship. This constancy is an indispensable condition for emotional stability. It is important for therapists to maintain it to be able to work on the instability of going and returning patients. By approaching and parting they will be able to carry out a process of growth and maturation, as long as this work is prepared and elaborated. The psychotic patient does not tolerate the uncertainty of not knowing who the other is, because he gives him the dangerous characteristics of the primitive object that led him to the mental illness. Isabella told me once: “I too need to know who you are. I know you are not going to tell me anything about you, but I need to know you and trust you. You won’t be like the yoga coach of my mother, who thinks he knows everything." Namely, we have to maintain a constant presence, but not any kind of presence, but an authentic one, which implies being able to bring into play the part of the reality linked to our very affections and emotions.

The patient needs to be remanded to the truth, and perhaps, first of all, we have to show our true selves, and assure him that we do not represent just another secret in his life.

This does not mean that we have to reveal us completely and tell our stories and secrets, but we should not have secrets in front of them and with them, and on some occasions, why not make them participate in something of our lives, from the position of companionship, if this can contribute to the cure; we have, nevertheless, to be sure that this does not stand as an act of our own countertransference.

I remember one morning in a multifamily group in which I moved from authenticity to acting out in a few seconds. Initially I was confused by Pablo’s father, by his ability to calmly use ideas and acts of his psychotic son. We later found out that in many cases, these behaviours were a way to ask Pablo to react, to show Pablo that he cared for him. In this group, Pablo became angry, got angry with me, stood up and threatened to leave. I got up and went to meet him to talk, to clarify and not letting him go, showing him, in my intentions, that I cared and I was interested in working with him. From this point a few seconds passed and we reached a face to face argument, in which I felt trapped, wanting to help but feeling unable to think, until one of my fellow co-therapists came and solved the conflict.

The co-therapy offers many more therapeutic resources and can function as a container for the intense emotions that can awaken, so that the therapist can be better preserved.

Starting from our errors, patients need to have a real encounter with the person of the therapist, with another that gets enthusiast for the genuine part of the patient, and is able to transmit his experience of happiness in encountering another human being.

The ability to establish a therapeutic relationship is not determined only by the psychopathological condition or by the disturbances caused by patient's Ego, but it depends largely on the ability of the therapist and on the real context of experience. To take charge of the patients does not consist of making a huge sacrifice, but of giving one's own a disposition at the right time, which, through the psychoanalytic attitude, our being permissive with the patient, and the ability to hold, permits to think and process what is going on in the clinical work letting the patient feel our genuine interest.

We should not offer a complete unconditionality, which could be suffocating for the patient or an excessive exercise of our narcissism and omnipotence in which we would transmit our own castration, our own insufficiency. The patients test our patience and ability to tolerate, challenging our resources, our ability to treat them, our authenticity and the reasons for our interest in them. For the primitive levels of the mind the emotional changes are more important than the mental ones; moreover, a merely intellectual approach does not only lead to no emotional change. Our mere presence, our affectionate physical contact, all have a greater effect than any interpretation.

In turn, patients will be with us until we prove that we can adequately take responsibility for them and that they can trust us, so that they can tolerate the attacks of the various forms of object relationship. Pilar was a patient who had an almost inexistent awareness of her disease, and with an incredible ability of scission, denial, rationalization and projection of the emotions and affections (primarily anger). At the beginning of a group, when I approached her to try to insist on the need for her to be cured because she was "ill", her answer was: "Angel, you are the one to be ill." And it was so, she did not feel any discomfort.

During the following days, when she was already hospitalized and I was on duty, I saw her walking in the hallway praying, and when I approached her she began to say, "God, let those angels be saints."

I tried to get closer to her and, as she almost always did, she side-stepped. In fact I preferred it because I did not know what to say. What I was really feeling was the need of asking her how I could be of help.

I keep thinking about how to approach and help this patient. Probably realizing that she asked me just to be there, remain in silence, bear her projections, understand that behind her refusal, her aggression and "infantile eroticism", she just needed my presence.

The therapists and the group must act as an adequate "container", in the sense of being able to support the burden of the most psychotic and regressive parts of the patients.

They actively make us feel what they passively suffered from their parents when they were children, thus challenging our ability to deal with these issues.

We can live this like a sadistic attack, or realize that they are stretching out a hand to help us understand them and redeem them from that place of pain. How difficult was it to tolerate the direct and indirect verbal aggression, disqualifications, the issues of Sandro's mother, a patient who, when I started having him in charge had already been doused in petrol and set on fire in a moment of psychotic decompensation with a strong depressive component.

Knowing that the patient must be able to externalize his disease in order to effectively begin a treatment, it is equally important to have the ability and the means to put appropriate limits in the therapy to allow them externalize their impulses, needs and requirements, without the fear of suffering damages that can be confirmed by reality. While protecting oursleves, we protect them and protecting them we defend ourselves, thus developing a "maternal" element with the creation of a sense of security to face pain, anger, despair. And we also create a "paternal" element, able to establish limits and rules and strengthen their personal borders.

Badaracco suggests that the real and profound demand coming from the patients is that we must be the "parents" they never had, functioning as objects that structure an immature ego, putting limits if it is necessary or redeeming the healthy parts to allow their development.

To take responsibility of this question in the multifamily group requires, on the one hand offering ourselves as objects structuring of this Ego, and on the other hand also redeeming the real parents beyond their concrete difficulties, helping them and replacing them taking their place. The opposition to change and develop comes not only from the "damaged" patients, but also from the opposition and the ambivalence of their family members. These hostilities are usually evident, but they are more manifest in certain occasions. This is why it is so necessary to accompany patients' parents in a genuine therapeutic process, in order to understand, from our side, and show it to the patient if it is possible, that one thing is the 'transferenced' parents internalized from childhood, and the other are the real parents of today, with their own stories and conflicts and shortages. This, not to fall ourselves into the trap of feeling the saviours, the best parents patients could really have, the ones who know how to cope with reality.

Patients' families form part of the group and this is obvious to the extent that each patient comes in the group with his own family, and actualizes it in the group, while the therapist brings it in.

I remember that a few months ago I pointed out with a patient, in a personal interview, that I needed to see his mother. He's a borderline patient to whose requests this woman does not put any limit, and this fact amplifies in him dependence as well as guilt. In the beginning he did not understand why I wanted to see his mother and claimed the privacy and exclusivity of this space for him. I tried to explain my reasons and I told him that, his mother was anyway present through him and in all of his speeches in the meetings. He said, "well, do you think your mother is not being here too?"

If the parents, who definitely did the best they could, are not helped by the therapist, in many cases they could not tolerate the situation due to the lack in their resources. For this reason, they try and keep the pathological complicity with their sons and daughters. Thus, they end up in the well known territories of mental disease.

On the other hand, if patients do not see their parents being sufficiently contained by the therapists, they can go back and close the door to the world and end up in the most terrible submission, identifying with their parents and returning to the former symptoms.

In a dramatic moment of Juan, a patient who prior to his hospitalization, a few years ago, ran out of his house towards the south of Spain with the intention of committing suicide (hitting his head with a stone) and is now much better, in the presence of the mother he began to say again that he thought of leaving home, that he had a new tattoo, that he was scared, because he had symptoms of a new impending breakdown.

I got up, I knelt down in front of his mother, the eyes of whom began to fill with tears, and I said, in a dramatic tone: "Look, Mom, I'm better, much better, and I'm very scared. Moreover, I fear that if I'm so good you will stop loving me and you will quit worrying so much for me! "

They both started laughing and Juan said, "that’s true". From this time on he continued to improve.

Patients feel so much relief both when we put limits on parents and when they perceive that we are helping them.

Parents can live with jealousy the fact that the patient may have a better bond with the therapist than with themselves. This is another aspect that we must protect.

We feel that we make a better fatherly role than their parents, thus entering into rivalry with them, so that they have no other way than failing.

In my experience, the ability to work in an individual therapy, the relationship with one’s own family is not enough. It took several multifamily groups, both as an observer and as a therapist to be able to change my perspective towards the parents.

Initially they were only "parents", subsequently they gained a proper name, but they were still "those guilty of."

After some time they became "those who also suffer."

To me, they passed from being just parents to be “people who are suffering”, who can not cope with things differently, who would not intentionally harm their children, who need our help just as much as their children (who have been labeled with the diagnosis). These parents, too, have their own story with their own dramas and inadequacies. This has completely changed my way of being.

In order to help the patient, it is crucial to support his parents to get out of the plot in which they are stacked; and offer them a lead to see if together, and with all others, we can try to get out of the maze. Since trust, conscious or unconscious, in each other makes it impossible to redeem some leaving others trapped.

But here are the parents, as real as transferenced, and they also need to be able to learn to share, to express, to experience a space of containment and support to learn themselves how to be containers for their children.

We're not merely giving them the fish, we are teaching them how to fish. If we talk about our need of resources to be genuine containers of patients’ Ego in this type of relationship, it is almost obvious to think that parents are provided with these resources and that it is our duty to offer them the opportunity of developing them.

We therefore pass from the plot of the schizophrenogenic guilty mother to one considering the needy and deprived parents.

The therapeutic team also plays this role.

I speak of the team and not just of the therapist because I think co-therapying and working as a team is essential. Firstly, to always keep in mind the whole family and the oedipal triangulation; secondly, to protect each other, redeem us in difficult moments, rely on more listeners to hear, more eyes to see and hearts to feel; thirdly, to dilute the transference and switch roles.

I think that transference is present in all groups, even when it is multiple and difficult to interpret, and even when we are talking about co-therapy, of the real presence of the family and also the non-transference of the relations that are established with the therapist and the other members, as the case of multifamily group, in which many patients and family members share the common areas in the same neighbourhood.

Compared to transference phenomena some other characteristics of what we call a "good- enough therapist " "affect" the clinical work, such as transparency, spontaneity, surrender to be trapped by a veil of silence passing by one who knows and can, authenticity, and human significance, including the physical contact and the answering, at times, to the perceptions of the patient with respect to him; and

also accepting the fact of being sad or happy at a certain moment; giving small examples our own life to increase transparency; developing interpersonal learning; using one's own sense of humour; being able to accept mistakes; waiving the idealized self image as an omnipotent father or mother.

But this does not prevent the emerging of group processes linked to the relationships among members that emerge through the transference; elements of relational structure, of symbolic and fantasized life, of each and every one of its members.

Our job is to create an environment that allows everyone to be what he can be, in a kind of "let things be". The point is to, paraphrasing Alexander, put up a therapeutic corrective family experience, in which emotional coherence, sense of humour, honesty, spontaneity, empathy, and the presence of the "transference" and "real" therapist, help disassemble defenses and shields so to foster a psychic change.

David was a patient with a psychotic structure and obsessive defenses, which constantly accused his father of everything, mainly for being so strict and demanding with him. He did a wonderful therapeutic process, accompanied in recent months by his parents in the Multifamily group; he had an interview with me a few weeks ago for the control of medications. At the end of the interview he apologized because, since I'm a doctor, he thought I could be offended in seeing that the note on which I wrote the date of the following interview had crumpled a bit. I showed offended at being treated like any other doctor, as if he did not know me personally reducing me to a generalization. I took the paper, I wrote a new appointment, and gave him the note ostentatiously crumpling it. Then, I "stretched" it a bit with my hands. When he took it, he told me with emotion, "birdie (he affectionately calls me that but I do not know why), I do not know how you are as a person, but as a doctor, you're the best. You do not know the amount of fear that you removed from me." And we hugged to say goodbye.

Within the team there are also many therapeutic countertransference phenomena coming from each member's personal difficulties, and from those arising in this relational game in which everyone has embarked.

We have to be very attentive to our countertransference reactions because otherwise they may cause in us the same frustrating attitudes the patients fear, leaving them stuck in a no exit loop.

If our process goes well, this different form of reacting and relating with the patient introduces a new dimension in his object-relational experience.

As Badaracco says, healthier structuring identifications will slowly produce in the patient's Ego, which will contribute to the mobilization and development of the therapeutic process. We can say that the patient "uses" us as a model.

I think it is extremely important considering the risk that Guimon showed (recalling a Racamier's idea), according to which the therapeutic equipe can get dissociated for patients' projections, and in the therapeutic work the personal difficulties arising from one's own issues (rivalries, tensions , stress, ...) may add up causing an increase of tensions within the team, demanding from its members a perfect way to understand each other at all costs, to present itself as an "ideal family" container in which patients will be able to grow.

This need of the members of the treatment team to simulate to be working like a happy family, denying the differences between them, may result in members of the group as a deposit of their denied and projected difficulties.

Such an equipe would not be good-enough for the patient, nor it would be able to accept its own limitations, its own challenges, its own battles and rivalries. This would be a team that, probably without being really conscious, hoped "that" group to work, even with therapists' own needs, desires and feelings, which are inappropriate for therapeutic relationships, and must be solved "in their own home", before going to distant houses.

Perhaps the advantages and difficulties of working in co-therapy will be discussed in another paper, in another space to think beyond this context.

It is important to remember what Meltzer and Guimon underlined, that we are challenged even in the most serious cases, to contain and create groupal spaces to think and feel about ourselves. These spaces of thought can act as a kind of cement (or supporting structure) that fills some of the weaknesses and insecurities of the nuclei of the autistic personality. This proposal can be integrated with Badaracco's one and facilitate a therapeutic process with a positive outcome, where there is a psycho-emotional growth and development of new and more "genuine" egoic resources.

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