Transcript analysis of Multi-Family Psychoanalysis Group and action research in a public Therapeutic Community

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Abstract

This article presents the perspective of a group of authors regarding their action research into the use of group therapy as a means to treat severe psychotic states in a public psychiatric therapeutic community. After recording various Multi-family Psychoanalysis Group sessions and analyzing the transcripts of these recordings, the authors were able to implement their findings as a guideline during their group therapy sessions.

Key words: therapeutic community, multi-family psychoanalysis group, action research, transcript analysis, Grounded Theory.

Multi-Family Psychoanalysis Group in the Urbania Therapeutic Community

We shall embark on a journey to a «submerged» world, a world where appearances hide true meanings, the world of symbols in which everything is significant, in which all is apparent to those who can understand (Feuerbach, 1971, p. 33).

Clinical work in a Therapeutic Community (T.C.) for the care of psychotic patients involves spending time managing both everyday life and ongoing emergencies. Emergencies which test limits and boundaries, flooding everyday scenes with real and imaginary elements that require understanding, processing, interpretation and intervention. The Multi-Family Psychoanalysis Group (MFPG) helps operators to activate and maintain a clear line of thought regarding the work done at the therapeutic community, the group therapy process and individual clinical situations. For group members it is a place for inter and intra family confrontation and discussion. It is an opportunity to change those bonds that produce and reinforce the psychiatric condition.

To make the best use of a certain clinical treatment it is necessary to be very familiar with it. For this reason, at the Urbania T.C. (Department of Mental Health, ASL ROMA 2) we have conducted qualitative research based on the principles of Grounded Theory (Glaser & Barney, 1995) aimed at analyzing the verbal interventions of MFPG participants. In this article we will discuss the two main categories (content and process) that emerged from the analysis of the transcripts taken from some of the therapy sessions. The results underline the distinctive characteristics of MFPG conducted within therapeutic communities and confirm the complexity and richness of this kind of treatment on psychoses. Furthermore, the findings highlight the ability of

these sessions in being conducive to reflection and shared discussion, validating the hypotheses present in the work of J. G. Badaracco.
The Argentine psychiatrist Badaracco in fact, laid the foundations for Multi-Family Psychoanalysis while working with groups, open to all those present, in a psychiatric hospital in Buenos Aires in the '70s. His main objective was "to be able to work on accosting one family to another, calling into play all their similarities, differences and contradictions in order to create new individual yet familiar structures" (Badaracco, 2004 p. 39). Badaracco therefore concentrated on pathogenic interdependencies and multiple transference in order to free a *healthy virtuality* and implement processes of separation from family symbiosis. The MFPG sessions at the Urbania T.C. are free to all who wish to participate but mainly target families, patients and former patients; They are led by two therapists whose aim is to encourage the transformative and healing powers of the group context and to strength the manifestations of metacognition. They also offer interpretations and promote and enhance all forms of *healthy virtuality*.

Research

The research that we put forward uses Grounded Theory Methodology (Glaser, Barney, 1995) to investigate the verbal communication and therapeutic processes contained in the transcripts of some the MFPG sessions. From an observational and exploratory perspective, we took the verbal communication produced as the expression and function of *group thought* and not as the "mere" sum of each of the minds present. Research in the psychotherapy field makes use of these methods, "... even if they do not offer any direct access to non-verbal processes or non-verbal markers during interpersonal exchanges; they are justified by the assumption that significant emotional and motivational processes will still occur at a verbal level, precisely because speech comes from a referential activity (Bucci, 1999) that connects words to sub-symbolic knowledge levels where emotions and motivational processes occur" (Liotti, Monticelli, 2008, p. 18). This project has allowed us to develop hypotheses regarding the function of MFPG and on the causality between the categories which emerged from the transcripts.

Method

Between October 2011 and July 2012 we audio-recorded 20 therapy sessions of which, for technical reasons, only six (1st, 2nd, 3rd, 4th, 14th and 16th) were transcribed and subjected to analysis according to the Grounded Theory Methodology text (Glaser, Barney, 1995; Glaser, Strauss, 1967; Strauss, Corbin, 1990). This method consists in the fragmentation of the initial transcripts into units of meaning (complete sentences) that describe a single phenomenon. A subsequent categorization of the units was then made from which the central categories, that have their roots in the

original group transcripts (Grounded), emerged. Two expert coders, with the help of specific software (NVivo 7.0.1281.0, SP4, QSR International ©, 1999-2007), then took the following steps: reading, open coding, axial coding, selective coding and identification of central categories. The central categories identified were thus denominated **processes and content.**

Processes

The group therapy process concerns the way a group functions as a whole; its changes, the interactions between the various subsystems and the way in which each of these systems interacts and is influenced by the group itself. It can be seen as "... a function that at every moment of a given period of time corresponds a certain state or configuration characteristic of an individual or community which is under examination" (Klimovsy, 1982, p. 7).
The analysis of the transcripts highlighted the following processes: Attack, Mutual/ Self-help, Cooperation, Irony, Manipulation and Attempt at recognizing other people's emotions.
Attack and cooperation are present throughout the analyzed transcripts; Mutual/Self-help and Irony are noted from the third meeting onwards; Manipulation is present in half of the sessions but in a discontinuous manner; The attempt to recognize the emotions of others appears only in the penultimate and final meetings.

Attack

By *attack* we intend a verbal communication mode in which a person is the object of protests, claims, accusations, put-downs and denigration. It includes attacks among siblings, between parents and their sons/daughters (the patients), from patients towards the operators and/or towards other patients and parents in the group setting. In MFPG sessions the attack between siblings is poorly represented. Attack towards one's children is also hardly present as a process, while parental anger is often evident in the content of their narratives. Patients do not attack parents who often attack the operators and the group.

Mutual/Self-help

Mutual/Self-help is intended when the members of a group try to help each other (Steinberg, 2002). It includes interventions on giving and asking for help and/or advice or, on the contrary, not being able to help. Parents give advice to other parents and other people's children, and ask for advice from the therapists; patients advise each other and ask for advice from the therapists. They sometimes advise the parents of other patients but rarely their own. The most represented process is that which sees parents offering advice, this is due to the fact that they see the other members of the

group as "mirror images" (Badaracco, 2004, p. 80) and feel like they are *experts*[1]. "This type of behavior highlights the pathogenic interdependencies of an individual's personal history. These can be treated therapeutically in order to transform them into forms of reflective thought which appear to the extent in which they produce the pathogenic disidentifications which inhabit each of us"(Badaracco, 2004, p. 81). The request for help and advice hardly occurs but when it does, it is aimed at the therapists and regards clinical and behavioral aspects. The inability to help one's self alone is expressed by patients, usually during the final session, an expression of them having an adequate grip on reality.

Cooperation

Cooperation, which can be seen as the highest expression of intersubjectivity in the course of human evolution (Tomasello et al., 2005), makes it possible to perceive one's self like another with intentionality. It is attained when two or more members of the same social group are interested in the achievement of a given goal, easier to accomplish through a joint effort (Tomasello, 2005). In order to perceive another as being similar to one's self through intentionality and to cooperate on an equal footing, with a view to a joint objective, reflexive functions are required. These can also be developed, exercised and expanded in MFPG sessions through a therapeutic alliance. In psychotic functioning families though, the therapeutic alliance is often damaged. It may however, be repaired in the group context as the broadened setting and the possibility to share knowledge allows members to appoint emotional experiences and the intentions reported within them (Liotti, Monticelli, 2008).
This category is characterized both by achieved and failed cooperation. Achieved cooperation is manifested in the form of agreement, facilitation of group work, proposal of joint work and respect towards the therapists. Failed cooperation is manifested in the form of disagreement, limitations in conduct/behavior and conflicts. Cooperation slows down, becomes difficult or fails completely when dramatic events (psychopathological relapses) burst onto the scene. In accordance with some authors (Liotti, Monticelli, 2008), we believe that painful events, with their burden of anguish, activate disorganized attachment patterns that reduce the cooperative and reflective skills of group members and invalidate the trust and hope in the group as a whole. In our experience, the failure of cooperation leads parents to become rigid and aggressive, invoking stronger and more restrictive measures while the patients express their disorganization through tears, fear, and distorted thoughts. The category of failed cooperation is always present, while achieved cooperation usually appears during the 14th-16th session.

It is possible to assert that the shared objective (the improvement of mental illness) remains central to all group participants. This is thanks to the committed participation

[1] This phenomenon is particularly noticeable in parents whose children are in the proceeds of improving

of each individual member and to the group's ability to process the subjective experience of "madness ... when shared, ceases to be madness" (Badaracco, 2004, p. 128). Badaracco believes that the group, with its element of containment, allows participants to analyze current situations which are a repetition of traumatic situations of the past. "The therapeutic process is to bring to light the existence of pathogenic interdependencies and subsequently try to induce de-identification or de-alienation processes of one or the other" (ibid, p.76).

Irony

Irony is a coded rhetorical structure in which one sais the opposite of what one wants to say without fear of judgment from others. It requires awareness of one's limitations and possible errors and promotes an implicit pact of complicity between interlocutors. It is considered a mature defense mechanism which allows one to deal with emotional conflicts and stress while creating less tension (Lingiardi & Madeddu, 1994). Present in sessions 3, 4, 14 and 16, it was noted being used by parents and patients while discussing mental illness, rituals and other subjects in general. After the consolidation of the initial phase, it seemed that participants could use irony more freely because they felt protected and not judged.

Manipulation

Manipulation consists in using more or less explicit behavior to achieve one's goals even without the consent or agreement of others. Manipulation within the MFPG session is physiological and, according to Badaracco, is a distortion of interpersonal relationships and a subjugation to partial interests. This category was present in sessions 2, 3 and 14, where therapists were manipulated by parents and patients and where parents were manipulated by their children. The parents on the other hand, did not manipulate their children perhaps because often they assume the role of co-therapists whereas the children manipulated them because, especially in the beginning, they fully identify themselves with the role of sick person. Parents and patients manipulate the operators to get attention and privileged treatment, but as symptoms start to improve, manipulative behavior decreases. This is shown in the transition from the representation of one's self as being in need of attention and care to a representation of one's self as being capable of giving and asking for help.

Attempt at recognizing other people's emotions

"The ability to empathize and mentalize, fundamental elements for the management of affiliative behaviors, are linked to the perception of a first-person perspective of a subjective experience. That is, the sense of *agency*, which is the ability to recognize one's self as agent of one's own actions" (Blundo, Ceccarelli, 2011, p. 70). In sessions 14 and 16, the patients manifested attempts to recognize the emotions of others and, unlike their parents, tried to take on the emotional perspective of others. The hy-

pothesis is that they have "learned" to do so during their (long) time in therapy and MFPG sessions become a safe place in which to put this behavior into practice.

Contents

This category is composed of**:** *Emotions displayed by both parents and patients, Relationships, Living in a Therapeutic Community, Mental illness (M.I.).*

Emotions displayed by both parents and patients

In sessions 3, 4, 14 and 16 parents express: Guilt, Shame and Fear (real and imaginary, of inner states, terror and no fear at all). In sessions 1, 2, 3, 4 and 14 parents express: Worry, Anger, Despair and Fear (of their child, real and imaginary, less fear of mental illness). Parents express their emotional experiences from the start, while the patients begin to express them from the 3rd session onwards. The real and imaginary fears are usually common to all participants. Parents fail to understand and to predict the behavior and symptoms of the children, who express fear and terror (of themselves) when they are tormented by auditory hallucinations.
Worry, Anger and Despair characterize the talk of parents while Guilt and Shame that of patients. It appears quite safe to say that the patients' emotions are related to their perception of being in the world, while those of the parents may refer to the sense of powerlessness generated by the long illness of their children.

Relationships

By relationship we intend the connection or rapport that is created between two or more individuals when they interact; in a group setting, the behavior of individuals is constantly activated and regulated by the relationship with their fellow members to whose actions and emotions they are "obliged to react" also for the known mechanisms of neuronal resonance (Rizzolatti, Sinigaglia, 2006).

This category is present throughout all the sessions and can be divided into two subcategories:

- **With family members** (always present) includes speaking of one's family, parent-child relationships and separations.
  An in depth look at the Parent-Child Relationship category:

  - *Parent-Child relationships:* are characterized by expressions of affection (anger, love and protection), of encouragement, criticism, rules, violence (inflicted on them by their children), disappointment and helplessness. Parents include in the relationship with the children all that has to do with their care (drugs, care centers and therapists).

- *Child-Parent relationships:* children express guilt and anguish towards the relationship with their parents. The mother is often described as weak and irritable while the father is seen as being more depressed, dominant, avoidant, jealous, unfair and irritable. Reliability and a good relationship with their parents on the other hand, are identified among the positive aspects.

- **With therapists** includes Psychologists, Psychiatrists (external expert) and Organizational Dysfunctions. This category is present in sessions 1, 2, 3 and 4 but particularly in the 1st.
    - The *Psychiatrist* category includes many states of mind, recriminations and criticism towards this professional figure (the difficulty in having direct access to the psychiatrist and his/her unwillingness towards greater emotional closeness).

A "normal" relationship is based on feelings of safety, trust and reciprocity, elements often lacking in psychotic functioning families. Due to the complex conflicts and dysfunctional bonds that characterize these families in fact, the **Relationship with Family Members** category is one of the most multi faceted."Conflicts are pathological because they produce pathogenic constraints of interdependencies which make it very difficult or impossible to process or resolve them. They appear as problematic conflicts and to effect change it is not enough to merely become aware of them; one needs to obtain certain changes in order to allow the mind to think and then to change" (Badaracco, 2004, p. 79). In our research, we have been able to note that parents equate the relationship with their children with the care of their illness. Instead, patients can also identify moments in the relationship with their parents which are not related to their illness and show particularly lucid analysis of the dynamics of other people's families.
We believe that patients oppose less resistance when asked to talk about themselves and their conflict ridden relationships compared to the parents. Possibly because they feel that they are in a protected environment, where they can explore the relational human mind and integrate the differences.

Living in a Therapeutic Community

This category is present throughout all sessions and includes: The present, The therapeutic value of Therapeutic Communities and Daily relationships between patients. In the category "The present" it is particularly interesting to note the existence of a sub-category, namely; the parent's motivation in participating in MFPG sessions. Parents participate in MFPG sessions in order to receive help, understanding, to support their children and because they themselves feel affected by the illness. The parents who do not participate on the other hand, do so because they have difficulty con-

fronting the illness issue, because they feel aggrieved or because they prefer to passively delegate the institutions with their "problem".
The subject of "participation" recurs throughout the first four sessions because during this stage the group is working on forming an identity for its self. However, in the final two sessions it is absent due to the fact that the group has by then acquired a solid status. New comers to Therapeutic Communities (both patients and their parents) rarely question the participation to MFPG sessions. On the contrary, towards the final phase of the study we noted how MFPG sessions were recognized as a safe and stable event, promoting feelings of continuity and integration in all participants.

Mental Illness (M.I.)

An ever present category which is divided into: Time, Awareness, Judgment, Functionality, Duration of the M.I, Personal Experiences.

An in depth analysis of the following sub-categories:

Awareness is divided into a further two sub-categories: Mental Illness and Health. The former is represented by: Acceptance, Absence of rules and Being aware that one is sick (all admit to being affected by an illness). Awareness of health regards both perceiving one's physical and mental state.
In the **Duration of the M.I.** category there are four sub-categories: Practical issues, The family is drained, Difficulties and Compulsions.
Lastly, **Personal Experiences**:

- Those **of parents** include difficulties regarding the relationship with their child (impotence, ambivalence, doubt). Feeling lost, threatened and even persecuted by their child and all that surrounds them.

- Those of **the patients** are characterized by anxiety, feeling threatened, exclusion, isolation and denial. However, personal resources (work, health, having objectives and hopes for change and recovery) and positive thoughts (peer support, contentment, security, competence and maturity) also emerge.

Within the group, participants seem to show a fair ability in dealing in equal measure both with aspects regarding M.I. and Health. Considering a bio-psycho-social model of health, these transcripts do not present a description of social health but rather physical and psychological health. We can only hypothesize that the social stigma inevitably leads people to distance themselves from society in general. In other words, individual well-being appears to be independent from the social context one belongs to (Ryff & Singer, 2004). Furthermore, although families appear tired and discour-

aged, they do not fail to appreciate the moments of sharing of pain and tend to avoid displays of drama.
While the personal experiences related by parents are mainly negative and focused on the management of the illness and the pathological behavior of their children, those of the patients themselves are more proactive. While still including feelings of anguish and threat, they do not give up on their hope and aim for a positive outcome. This is probably due to the fact that their course of treatment (including their time spent in a Therapeutic Community) reinforces confidence for their future, while for parents it has a role of containment. Patients feel valued in MFPG and are able to recover the ability to imagine themselves in a different way, activating their internal resources and putting into practice healthy behavior patterns.

Conclusions

L'uccello di fuoco della mia mente malata, questo passero grigio che abita nel profondo e col suo pigolio sempre mi fa tremare perché pare indifeso, bisognoso d'amore, qualche volta ha una voce così tenera e nuova che sotto il suo trionfo detto la poesia (Merini, 1983).
[The firebird of my sick mind, this gray sparrow that lives in the depths and with his peep always causes me to tremble for it seems helpless, in need of love, sometimes has a voice so tender and new that I dictate poetry under its triumph.]

A long and arduous research, due to lack of funds and the complexity of the qualitative analysis undertaken, our work has nonetheless, produced fundamental stimuli and reflection for Therapeutic Community operators. In addition, it has confirmed many clinical observations and insights and allowed us to modulate the target of therapeutic interventions in MFPG sessions without straying from the Community Care System.
The consistent presence of processes such as; Attack, Mutual/Self-help and Cooperation allows us to hypothesize that they represent the basic characteristics of Therapeutic Community groups. But what is even more striking is the constant presence of the Failed Cooperation category because it refers to the importance of some of the procedural variables of the group such as cohesion, atmosphere and therapeutic alliance. Group cohesion refers to the sense of belonging felt by the members and the bond that is created between them, their ability to trust each other and to share personal emotional experiences. It is thus linked to factors such as involvement in group activities, mutual trust, cooperation and caring. A therapeutic alliance in MFPG, intended as the relationships between group members and therapists, therefore, requires particular attention because it ensures the ability to pursue the goals of therapy. Another important factor which must be monitored in each session is the atmosphere within the group as this determines involvement, conflict and/or avoidance between participants.
Finally, the Relationships category in the *Content* section, confirms without any doubt, the theoretical constructs of J.G. Badaracco: thus, intra-family and inter-family relationships are the primary focus of our intervention because only in the large

group context do the extreme dysfunctions come to light. By sharing and reviewing as a group, the dysfunctions which create and reinforce psychological illness may be reversed and a pathway to healthy behavior created.

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