Good evening everyone.

I'm very excited to be here with you to present my work.

I apologize for my English, I am not very fluent and feeling nervous makes it all the more difficult for me to speak.

I will make a brief introduction and will then give the floor to Joe, who is familiar with the book.

I am a very curious and persistent person. I have chosen this profession, which I am still passionate about. In my youth I did various types of training, none of which satisfied me completely, until I realized that the secret was in what I was already doing, that is, integrating. I later discovered that I was naturally relational at heart. The spirit of integration that inspired the first steps of the relational movement has guided me in this enterprise. Beyond school divisions, the clinician needs tools, he/she needs to keep the mind and senses open in order to grasp as much as possible the experience with the other who comes to us for help. In order to do this, it is indispensable to exercise this particular form of attention towards the emotional world and at the same time to continuously explore the theoretical categories that we use, both wittingly and unwittingly. So it is impossible not to have a theory; what matters is that one is aware of it and treat it as a tool, not as the ultimate truth, maintaining an attitude that is open to exploration and the necessary humbleness, understood as the awareness of one's human limitations.

So clinicians benefit from theories, but they learn early on that experience is irreducible and requires a sense of adventure and flexibility.

Therefore, an important point is: which theory is used to decode experience?

The Relational / Multi Motivational Therapeutic Approach (REMOTA) shows that it's possible to combine Relational Psychoanalysis and Motivational System theories

This has been my focus in writing the book.

Post-modernism, constructivism and phenomenological thought constitute the philosophical framework within which the relational movement developed.

There is no one truth to which the analyst refers; rather, the theories, with their differences, constitute a point of departure; these are hypotheses to be verified or invalidated through the direct experience of the analytic relationship, which is unique to every patient and can never be reproduced in the same form. It is therefore possible to offer different explanations of phenomena, all of which are potentially viable, based on the experience that is shared and co-constructed with the patient, as we learn from Hoffman (1992).

This position elicits interesting reflections on the possible search for universal invariants - such as motivational systems - that govern the mental functioning of our species, and therefore on the intent to formulate theories that take into account both the universal and the personal elements as constituents of the intersubjective experience.

Over the years, relational psychoanalysis has become ever more open to the latest developments in neurosciences, although there are still some criticalities in relation to one of its basic assumptions; in other words, there are no universally accepted objective explanations which the analyst can refer to as if they were certainties. As I see it, these positions are only apparently incompatible in clinical practice; in this respect, paradoxically, I feel very much a relational psychoanalyst. I think we would need another evolution - like the one brought about by relational psychoanalysis - in the direction of a psychotherapy/psychoanalysis that integrates knowledge as far as possible, overcoming barriers and focusing to a greater extent on clinical work.

What is the theoretical paradigm that has allowed me to integrate different theories and models?

Here I have to make a preliminary remark: a recurring and invariant theme in all cultures is the problematic nature of the concept of the *mind-body* binomial, in relation to which many different theories have developed - implicitly and explicitly - in various areas. In Western philosophy various paradigms corresponding to the different formalizations of the problem have succeeded one another:

- *the dualist paradigm,* according to which human nature consists of two different and separate entities: the body and the mind.

- *the monist paradigm,* which upholds that the two entities flow into each other.

The *multidimensional relational paradigm,* according to which the mind is a manifestation of the relationship - seen in its historical-temporal dimension - between the body and the world.

A holistic culture that integrates knowledge promotes the development of multidisciplinary theories – both biological and psychological – which, avoiding the compartmentalization of knowledge, provide more comprehensive answers while respecting the uniqueness of human nature, favoring as much as possible the “vis medicatrix naturae” (inborn self-healing powers).

Therefore, the basic concept of the Relational Theory of Mind that is referenced by the REMOTA model, can be summarized as follows:

The mind consists of the representation of the relationship between body and world. This representation is sustained by a multiplicity of inborn tendencies to interact with the environment, which are philogenetically inherited. The inborn tendencies are hierarchically organized in relation to representational complexity in the course of the individual's ontogenic development.

According to such a view, there are invariants that are genetically transmitted, influenced, and modified by the history of the evolution of species; these invariants constitute a universal foundation, that is, *values*, as Edelman (1989, 1992) calls them. Values define the limit of human relational possibilities. From this perspective, the focus of a caretaking relationship becomes **exploring the personal ways in which individuals, within their specific relational context, develop and use the genetically predisposed mental functions that the entire human species is endowed with**

Since the main tool of psychotherapy is the relationship and the primary means of communication are emotions, a theory that attempts to explain how we work inevitably informs us on the meaning of emotions - which are a vehicle of intentionality and of mental life - and, therefore, on the nature of the relationship that we are engaged in.

In this sense, multimotivational theories, which developed in the areas of cognitivism (Gilbert - Liotti) and psychoanalysis (Lichtenberg), identify the universal invariants that govern human relatedness, starting from evolutionism and infant research, and provide us with a useful framework for exploring the emotions that make up the fabric of the clinical exchange, at different levels of functional complexity.

I am very grateful to Joe and to Gianni Liotti for giving me the opportunity to discover the motivational perspective, but, more importantly, I am very close to them. In the book I have tried to describe, through the use of clinical cases and some theoretical reflections, the similarities and differences between the two theories, and especially how the two models can be easily integrated in my clinical work.

At this point I should briefly say something about the Relational/Multimotivational Therapeutic Approach: it is an outpatient treatment for traumatized patients with personality and dissociative disorders, with a very simple structure:

combined individual and group psychotherapy is organized and presented to patients as one treatment - an individual session and a group session once a week. Treatment begins with individual therapy. The patient is followed by the therapist for about one year, or for the time required for the therapeutic couple to build an alliance that is strong enough to endure difficult moments in the relationship.

During this initial phase, the therapist focuses on evaluating the problem presented, identifying the patient's personal resources and understanding the patient's affective context (contacts with the family and/or school setting, social workers, or others), which will become part of the therapeutic network. From the outset, psychopharmacological treatment is integrated into the therapeutic program.

After the initial phase, which lasts from a few months up to one year, the therapist and patient decide to begin the group sessions, alternating group and individual sessions. All the group sessions are tape-recorded and filmed, filed, and made available to patients and therapists. These recordings are a therapeutic tool that can be used by the patient on his/her own, in order to focus on some interactions and reflect on them, as well as with the individual therapist, in order to comment on what has happened.

While the double setting structure is simple, the therapeutic relationship that develops is highly complex and requires adequate skills and flexibility.

In the book I try to show how the transition from the individual to the group setting facilitates mentalization processes inasmuch as it allows the therapeutic couple to work on itself, at different levels of functional complexity, according to a biopsychosocial consciousness model which integrates neurobiology and psychosocial knowledge, multimotivational theories and a relational psychoanalytic approach.

In REMOTA, *negotiation* and *alliance* are expressions of the dynamic nature of the relationship between the therapist and patient, in which each individual's particular way of functioning - Internal Working model (IWM) - (Bowlby, 1969), which is the main focus of therapeutic work, emerges. The alliance is not based on the activation of the collaborative motivation alone but must take into consideration the attachment motivation; indeed, it is the result of a harmonious synthesis, created each time by the therapist and patient, of the different combinations of motivational systems that are active in the relationship and are based on the priorities required by the circumstances, the therapeutic context, the patient's context of life, and the resources at play.

In order to address integration and mentalization deficits, we often need to start from simpler mental processes and gradually proceed towards greater complexity, attuning ourselves to the patient's level of functioning, i.e. the "proximal development zone" (Vygotskij, 1962), during the various phases of therapy, using a language that is conducive to collaboration and growth. During the initial phase, when disruption distorts the interpersonal

motivational dimension, it is necessary to take concrete steps to protect the relationship and start therapy. The aim is to recover a level of complexity that the patient can cope with. Even when important goals and behaviors are being addressed, the therapist's attention needs to remain focused on the patient's relational style (IWM).

Another significant aspect of this model is the " Group dimension".

The group, in fact, is an essential element of our life, in which relationships are regulated by at least four innate motivational systems – the affiliative system (the most important), cooperative system, social rank system, and social play system - which intersect each other in different ways. In REMOTA, the group is not merely a therapeutic setting but a crucial relational dimension, always present in our lives and in the various stages of the psychotherapeutic treatment.

In my model, one works with and on the group, focusing on the patient's context of life, sometimes involving relatives and other significant persons. The therapist broadens the scope of observation and work from the outset, gradually establishing the approach and timing. Involving the patient in a joint exploration of the possibility of a therapeutic intervention opens the dual relational context to the *metacontext* in which therapy takes place: the patient's life. The timing of this therapeutic step is determined on a case-by-case basis.

The group is regarded as a source of stimuli that encourage individuals to express their own relational style, as in the intersubjective and relational psychological perspective. Relations between group members therefore carry therapeutic potential (Yalom, 1995). The therapist is empathically and actively involved in the group and favors interpersonal interactions and exchanges, directly facilitating an analysis of the verbal and non verbal communication. One works simultaneously on each patient's IWM and on the group as a whole, bearing in mind each patient's individual journey. Every individual begins to work on his/her own ability to understand the other's intentions according to his/her own specific IWM.

This therapeutic approach integrates various theoretical-clinical contributions and considers the group as a whole (Bion, 1959; Foulkes, 1975) as well as the individual group members and their personal therapeutic process.

The other distinguishing feature of the REMOTA model is the interconnection of group psychotherapy and individual psychotherapy.

The individual therapist is also present in the group, thereby lending continuity to the therapeutic work and favoring timely interventions that have an impact on the relational process under way. The fact that therapist and patient move from one session room to the other is the most significant element.

When the therapeutic couple has established a common space for collaboration, the therapist "goes with" the patient into the group. Before this happens, the patient must first address the relational difficulties he/she may have with the therapist, in order to create the alliance's basis - what I refer to as a "free zone"- to set out from and go back to in the stressful moments he/she will face during group therapy. Such an experience creates interesting opportunities for therapeutic work, as a dual setting of this type offers the opportunity for new relational scenarios.

Entering a group provides more opportunities to reflect on interaction with others and to become aware of their personality traits. Work with the patients takes place in the two session rooms as well as in their real life and involves many people. Their companion, however, is always the same, i.e. the therapist, whom they dialogue with constantly. This experience will have an impact, both implicit and explicit, on their IWM. The group therapy context may also give rise to scenarios in which it is easier for patients to recall "model scenes" (Lichtenberg, 1989) that are relevant to their own family group and the first social groups they belonged to.

The main goals of REMOTA group therapy include the promotion of cohesion as the development of a sense of solidarity that holds the group together. The level of cohesion is an expression of the group's ability to function in an affiliative and cooperative way.

Overcoming the natural conflicts that arise when different minds meet, as well as the personal traumas of the participants in a group, makes it possible to achieve a state that may not appear to be as useful as the agonistic states, but is no less important or existentially significant. The feeling of calm and wellbeing experienced when one exchanges a look of complicity with, or feels affective closeness to, someone else is a fundamental value for us human beings. It is a reflection of our sense of vulnerability and of our strength.

The group can be regarded as the common space in which differences are accepted, people are confronted with others who are different from them, and diversity is used as a resource that can help to pursue common objectives within an affiliative, meta-motivational framework.

Reflecting on groups and their dynamics, and understanding the context of our life and that of our patients, allows us to approach our individualistic culture with a critical mind and

provides instruments of care that resonate directly with our social and economic context.

At this point you might think that my book is a theoretical treatise, and it is, but most of the text is about clinical stories and the theory emerges from experience, as it has been in both my professional and personal life.

Thank you.