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# The adolescent body: a unitary and recursive perspective on the growing I-subject

*Eleonora Maria Paola D'Onofrio**

ABSTRACT. – In Relational Psychoanalysis it is possible to deal with corporeity and, in particular, with the body hyper-invested with meanings and signifiers of the adolescent, through the epistemic paradigm of complexity, which looks, first of all, at the I-subject as unitary, that is, for which, according to Michele Minolli, "the single part is the whole and [...] the whole is the single part". "The I-subject is one [...] has several parts in relation to each other. The various components or the different functions must be grasped in their interaction. A model that only captures the aspect of unity and does not help to understand the recursive functioning of the subject between its parts and the whole is not adequate". An I-subject, therefore, configured by its environment – familial, transgenerational and cultural – and by its genetics also for being 'that specific body', where the patient's suffering arises from perceiving himself as inconsistent, that is, from not taking note that one is as one is also as a unique corporeality, with which one is called to come to terms; taking into account, moreover, the context of a hyper-individualistic society in which, according to Lipovetsky (2004), we are immersed, which tends to make the body a fragmented instrument of self-affirmation, also through the narcissistic and global use of the visibility provided by social networks. Within this 'fractal' perspective, the symptom, which has bodily manifestations (self-harm, impulsive actions, attempted suicide, eating disorders, somatizations, anxiety/panic attacks), even, especially in adolescence, in terms of identity manifestation (tattoos/piercings/earrings, clothing, make-up/hairstyles), can then find its meaning as a metaphorical and syncretic expression of all that I-subject, according to the recursive logic of 'I am my symptom'; also intending the bodily symptomatology always in a relational perspective, since the mind is intersubjective, that is, identity and consciousness are formed in the context of relationships and not in intrapsychic isolation. In this sense, the symptom is also thought of as an expression of the patient's bonds; through the presentation of the clinical vignettes of some adolescent patients encountered within individual and family devices, we will try to highlight how it is, then, possible to work together with each specific I-subject in its complexity, in the present and embodied moment of the analytical relationship between two or more unique corporeities, therefore also including that of the therapist, in turn seen starting from his own initial configuration.

*Key words*: corporeity, adolescence, recursivity, symptom, relationship.

*Psychologist, Psychotherapist, Psychoanalyst, and ordinary member of SIPRe; SIPRe delegate at IFPS; individual, group, and family Psychotherapist at Rehabilitation Care Community and Day Care Center "Olallo Valdés" for DAN treatment, Centro Sant'Ambrogio Fatebenefratelli, Cernusco sul Naviglio, Milan; Psychotherapist PsiQO Association, free Psychological Consultancy Center for Adolescents, Quarto Oggiaro, Milan; Co-founder and Member of the 'Centro Arcipelago', Italy.
E-mail: donofrio.eleonora@gmail.com

## Introduction

This article is the result of clinical urgency. It arises from years of doubts, comparisons, and study regarding the legitimacy of psychoanalysis dealing with corporeity and, therefore, with symptoms. It arises, obviously, from the need to respond to the question of some patients, especially the youngest, affected by what, today, we would call a 'new symptom', such as, for example, an eating disorder, and who need to deal with 'that' body and 'that' symptom, freely, in therapy. This position can have a strong impact on the clinician, even defensively, because, as Fabio Vanni says:

> "Putting one's body into play [...] is not an obvious step, it means abandoning an intellectualistic plaster cast that preserves us and that perhaps has accompanied us for many years, it confronts us with an image of ourselves that may be a little different from the usual one, it can put us in contact with sensations and thoughts that concern us that are less reassuring, perhaps transgressive, than the figure of an analyst as we have always thought of him. But naturally it can allow us to see different aspects of the people in front of us, who in turn play a different game than that of the simple 'talking cure'." (Vanni, 2015, p. 1375)

I also think that it is not possible to deal with corporeality and symptoms if the unique subjectivity of each patient is not taken into great account and that, therefore, only a model that takes into consideration 'that' patient or 'that adolescent as the subject of the relationship' (*ibid*., p. 367) may be effective in the face of somatic symptoms.

I know for sure that it could be said that we psychoanalysts 'do not deal with contents', but again, to quote Vanni:

> "We are not so much interested in the contents themselves, but in order to speak, it is useful to have contents to talk about, like children with the ball or adults with politics. We can be interested in the contents of the political discourse that a person expresses, or we can look at which aspects of him that discourse reveals, for example, his aggressiveness, his calmness, or his pessimism. It is the second perspective that we choose. We add that what we will observe in his saying is the whole, that is, we will observe how his being subject of the relationship moves in the specific situation, the tone of voice, the rhythms, the posture, *etc.*" (Vanni, 2015, p. 1796)

Today, I have personally come to the idea that Relational Psychoanalysis can deal with corporeality and, in particular, with the body hyper-invested with meanings and signifiers of the adolescent, through the epistemic paradigm of complexity, which looks, first of all, at the I-subject as unitary, that is, for which, according to Michele Minolli:

> "The single part is the whole and [...] the whole is the single part." (Minolli, 2015, p. 77) "The I-subject is one [...] has several parts in relation to each other. The

> various components or the different functions must be grasped in their interaction. A model that only captures the aspect of unity and does not help to understand the recursive functioning of the subject between its parts and the whole is not adequate." (*ibid*., p. 74)

In order to understand the body theme in psychoanalysis, in fact, in my opinion, it is fundamental to keep in mind the concept of recursion, since, as Marcello Florita says, "the same result can be obtained starting from different initial conditions; in the same way, similar initial situations can lead to different outcomes" (Florita, 2011, p. 21).

The I-subject is configured, historically, by its environment – familial, transgenerational and cultural – but also by its genetics to be 'that specific body', "only he or she has those eyes […] that skin […] that gender belonging",[1] where the patient's suffering arises from perceiving himself as inconsistent, that is also from not taking note that he is as he is also as a specific corporeity, with which he is called to deal, since "implicit in suffering is the active non-acceptance of the fact";[2] taking into account, moreover, the context of a hyper-individualistic society in which, according to Lipovetsky (2004), we are immersed, which tends to make the body a fragmented instrument of delegation or self-affirmation (Minolli, 2015), also through the narcissistic and global use of the visibility provided by social networks.

Deservedly related to the theme of corporeality, the most powerful aspect of the theory of non-linear complex systems is the emphasis on "the processes of self-organization specific to every living form" (Minolli, 2009, p. 37), which in 2015 Minolli will take further with the concept of historical configuration, "arguing that the I-subject is configured by genetics and the environment is a meta-theoretical point of view that allows us to take into consideration the single and particular I-subject. The I-subject is what it is because it is the result of the modalities that configure it" (Minolli, 2015, p. 119): the theory of complex systems has, in fact, above all, the merit of creating models for the study of the emergent properties intrinsic to the processes of organization between physical and socio-human elements and of being able, therefore, to deal with the unrepeatable uniqueness of each I-subject. For Morin, "it is interesting that a system is at the same time something more and something less than what could be defined as the sum of its parts. In what sense is it something less? In the sense that the organization imposes constraints that inhibit certain potentialities that are found in the various parts" (Minolli, 2009, p. 38). Or, as Maturana and Varela say:

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[1] Lecture by Minolli M. at the Parma Center of Italian Society of Relational Psychoanalysis (SIPRe), 2016.

[2] Lecture by Minolli M. at the Milan Center of Italian Society of Relational Psychoanalysis (SIPRe), 2014.

> "Autopoietic machines are homeostatic machines. […] it follows that an autopoietic machine continuously generates and specifies its own organization through its operation as a production system of its own components and does so in an endless turnover of components under conditions of continuous perturbations and compensation of perturbations." (Maturana & Varela, 1980, p. 131)

Studying a complex system, therefore, means studying how the development of forms (both physical and social) derives from the emergence of organized patterns generated by the same forms, by the same systems, that is, as Elia says, "conceptualizing the Self as a systemic organization constituted by a complex interaction of affective-symbolic and sub-symbolic subsystems (I refer here to the formulations of Bucci, 1985, 1997): these should be considered as process modules implemented by biological systems *tout-court*" (Elia, 2013, p. 113). In short, attention is paid to the bottom-up processes of space-time self-organization produced by each minimal interaction in a relational environment. Only by thinking of the human as a complex system that self-organizes, we will be able to see the individual re-emerge in all its ethical and symbolic significance.

Within this 'fractal' perspective, as Mandelbrot would say (1987), the symptom, which has somatic manifestations (such as, for example, self-harm, impulsive actions, eating disorders, somatizations, panic attacks, or even attempted suicide), also, especially in adolescence, in terms of identity manifestations (through the use of tattoos/piercings/earrings, clothing, make-up/hairstyles) can then find its meaning as a metaphorical and syncretic expression of that whole I-subject, according to the recursive logic of 'I am my symptom'. The term 'symptom' is a derivative of the Greek συμπιπτω (*sympipto*) and indicates an event that happens with something else. My point of view on the symptom, which emerged from clinical experience and theoretical comparisons, follows the idea that it is like a dream for the dreamer, according to Minolli's perspective, "the dream represents in a metaphorical and syncretic form the functioning of the specific I-subject that dreams it [...] it is the mysterious way in which the patient decides to communicate himself and to communicate something to us".[3] Therefore, I would define the symptom as a hermetic metaphor for its ability to compare us with something similar, but which remains implicit; it is a signal, since part of what is implicit is the need to communicate suffering. In fact, it speaks to the analyst, but it also speaks to and about those who suffer from it; it informs of suffering, but also of one's own being in things, in the relationship with oneself, the body, others. The psychoanalytic symptom is given the possibility of being unsaturated, open,

[3] Lecture by Minolli M. at the Milan Center of Italian Society of Relational Psychoanalysis (SIPRe), 2012.

sure of an explanation not yet reached, of being suffering, but also a resource. I also mean bodily symptomatology always in a relational perspective, since the mind is intersubjective, that is, as neuroscience also teaches us, identity and consciousness are formed in the context of relationships and not in intrapsychic isolation. In this sense, I also consider the symptom an embodied representation of the patient's significant bonds and investments. As Minolli (2016) argues, "Human beings tend to make investments based on what makes them feel alive. They tend to affirm themselves through investment. This happens without them having a clear awareness of it, while still supporting the need to present themselves as existing, starting from what they feel at that moment".

## The adolescent body

To come to adolescence, when we talk about it, we are referring to a phase of life characterized by profound transformations, not only physical, but also psychological and identity related. The growth of the body is, especially in this phase of life, closely intertwined with the development of the ego and subjectivity. As Vanni says:

> "The discontinuities that the adolescent encounters in this period can certainly concern both the pubertal and post-pubertal biological transformations and the social expectations (of peers, of adults) but if we want to give the right attention to individual evolutionary trajectories (Cicchetti & Cohen, 2006; Rutter & Sroufe, 2000) we must put at the center the specific asperities of that adolescent and the subjective configuration with which he/she encounters them gradually." (Vanni, 2015, p. 501)

During adolescence, in fact, the body undergoes rapid and, often, dramatic changes and becomes a central element in the construction of personal identity. For the adolescent, these bodily changes require a reworking of the self-image, since he or she must integrate the new physical appearance with his or her mental image and with the sense of continuity of the self: he or she is, above all, called to deal with a body that is no longer that of childhood but is not yet completely that of an adult. This process can generate internal conflicts and anxieties, but it is also an opportunity for the subject to explore new dimensions of the self, including those related to sexuality and gender. The adolescent body is not only an object of change, but also an active subject in relationships. The perception that the adolescent has of himself or herself is, indeed, also influenced by the way in which the body is perceived by others: relationships with peers, parents, and other significant figures take on a new meaning in this phase, since the body becomes a vehicle of communication, attraction, and comparison. Relational dynamics can, then, profoundly influence the way in

which the adolescent experiences his or her own body. For example, judgment or criticism from peers can have lasting effects on self-esteem and body perception. Conversely, positive experiences of recognition and acceptance can foster greater integration and acceptance of the new body that is developing.

Finally, adolescence is a period of exploration and experimentation, in which the body becomes an instrument through which the I-subject explores the world and itself. This phase of life is characterized by a desire for autonomy and independence, and the body often becomes the field in which one experiments with the limits and potential of the self and the relationships in which one is inserted. Through fashion, sports, sexuality, and other forms of expression (tattoos/piercings/earrings, clothing, make-up/hairstyles), the adolescent uses the body to explore new aspects of his/her identity and to test the way in which he/she is perceived by others. This experimentation is an integral part of the process of growth and development of the I-subject.

During adolescence, therefore, the body can become the scene of internal conflicts, especially in relation to emerging sexuality, desires, and social and cultural pressures, also because, often, adolescents can have difficulty verbalizing their conflicts and anxieties, leading tensions to manifest themselves through the body; also for this reason, I believe that particular attention to the body can be relevant in clinical work with patients of this age group. Hormonal and physical changes can, in fact, be accompanied by intense emotional experiences that can transform into psychosomatic symptoms or other forms of somatization.

A unitary and recursive perspective on the growing I-subject, such as the one I propose here and within which I also move in my clinical work, is therefore, in my opinion, central to being able to work with the adolescent, as it can consider the typical transformations of the subjects of this phase of the life cycle in an integrated way, recognizing that the body is not an entity separate from the psyche but an essential and relational dimension of subjective experience. A unitary perspective on the growing I-subject also recognizes that the conflicts typical of this age phase are not only manifestations of discomfort but also attempts by the I-subject to manage and integrate new experiences and to find a balance between its internal needs and external expectations. Despite the changes that characterize adolescence, the body is, in fact, also an element of continuity. While the adolescent goes through the difficult process of separation from childhood and parental authority, the body offers a tangible and stable point of reference and can become a resource in the chaos: even if it changes, it accompanies the individual throughout the growth process, providing a sense of permanence that is fundamental for the development of a coherent and stable identity.

I therefore align myself with Vanni's position in *La consulenza psicologica con l'adolescente* (2015), already widely exposed in the introduction to this

work, but which I further underline here in its application to the world of the adolescent, when he says:

> "I find the point of view on development proposed by Michele Minolli (2015) very stimulating when he assumes as the primary reference area of the discourse on the human being not a class of individuals defined by common characteristics (age, diagnosis, *etc.*), but the specificity of that […] 'I-subject' configured at […] conception by genetics and environment in a specific way and which then develops its own unique and unrepeatable life trajectory also in relation to the context […] in which that life itself is placed. I believe this theoretical proposal, which places the single and unique subject at the center, can be usefully assumed as a development perspective for us too." (Vanni, 2015, p. 424)

And again:

> "Even Morin (2004) and Ford and Lerner (1992) propose a vision that we believe to be shared and fundamentally congruent with that of Minolli […]. The great French 'complexologist' writes: He [the adolescent] thus asserts himself in a privileged and unique site, in which he becomes the center of his universe and from which he excludes every other congener, including the homozygous twin. It is the exclusive occupation of this egocentric site that establishes and defines the term subject." (*ibid.*, p. 430)

In short, "we are interested in how that unrepeatable 'subject of the relationship' (Manghi, quoting Morin, calls it 'ecological subject', 2009) is in the world." (*ibid*., p. 1288)

## The adolescent body: the clinical implications of a unitary and recursive perspective on the growing I-subject

In relational psychoanalysis, as we have seen, the body can therefore be seen not only as a biological whole or a vehicle for drives, but as a living and relational experience, as the place where relationships are embodied and where relational dynamics are expressed, often in non-verbal ways, in the logic of 'I am my bonds'. This means that bodily experiences, sensations, and physical symptoms can be interpreted as manifestations of relational experiences, sometimes unconscious, and the body can therefore be, especially in adolescence, a vehicle through which one communicates with the other. A relational psychoanalysis, as we have seen, constitutively focused on the sense of unity and consistency of the I-subject, can help the patient to reach the perception of a greater integration between body and mind. Working with the patient in his entirety, in fact, makes one breathe. Within this perspective, the symptom finds its meaning as an expression of 'all that I-subject' and I can work on it by working together with that specific I-subject as a whole, in the

present and embodied moment of the therapeutic relationship. This can happen through awareness of one's own bodily sensations (of the patient, but also of the therapist), the recognition of bodily signals in relationships, and the exploration of how the body has participated in the construction of past and present relationships.

Postures, movements, facial expressions, tone of voice, and other forms of non-verbal communication can play a crucial role in the therapeutic relationship. Within this perspective, the interaction between patient and therapist is an intersubjective field in which both participants influence and are influenced, and it follows that the corporeality of both is part of this dynamic. The therapist can, in my opinion, be as aware as possible of his own body, of his somatic reactions, and of how his own body interacts with that of the patient. At the same time, the therapist can try to understand how the patient experiences his own body in the therapeutic relationship. As Vanni says, "The consideration of the focus of our interest on 'that specific subject of the relationship' must necessarily be declined also on the side of 'that specific analyst' trying to develop a relevant theoretical vertex, also central among relational psychoanalysts" (Vanni, 2015, p. 520). The therapist can then consider the patient's body as an active partner in the therapy. The focus is on the awareness and exploration of bodily sensations, muscular tensions, somatic emotions, and visceral reactions, which can emerge during the therapeutic session. This can lead to the understanding of unconscious relational patterns and the discovery of symbolic meanings in body language. The technique therefore allows the use of specific approaches to work with corporeity, such as body psychotherapy, which incorporates bodily approaches such as breathing, muscular relaxation, and body awareness, or active methods such as psychodrama, psychomotor skills, art therapies; these devices can help patients connect with their bodily experiences and explore the connections between the body, the mind, and interpersonal relationships. Through attention to corporeity, relational psychoanalysis can ultimately aim to promote the integration of bodily and psychic experiences, promoting self-awareness, understanding relational dynamics, building a work that welcomes the symptom and can insert it into a broader framework of meaning for the person who suffers from it.

Below, and to conclude this exposition, I would like to indicate how I tend to apply the considerations exposed so far in clinical practice through some cornerstones of the technique that I use and to which I refer, accompanied by some examples taken from fragments of sessions.

*The consistency of the analyst*

It is a being-there that is as frank, direct, respectful, even grateful as possible, as also suggested by Nancy McWilliams (Psychoanalytic Psychotherapy, 2006); in this way of 'being', I have a direct thought to suggest

the structural unity of the I-subject, as well as the possibility of integration, of which I found a great example in Frieda Fromm-Reichmann:

> "The center of Frieda's technique with patients […] was not so much […] interpretation as […] the communication of an understanding […]. It seems to me that Frieda Fromm-Reichmann's success was based not only on her knowledge and experience but also on the exceptional character qualities she possessed […] Frieda was completely there with the patient. […] She faced the patient firmly, with the presence of her entire personality – simple and direct, without pretensions and without grandiose ambitions – erasing the barriers of convention. She remained totally open, with broad attention. Frieda was capable of waiting […]. Even if a patient was profoundly deteriorated, she could glimpse the potential for integration of his entire personality. […] She was, above all, a clinician with great practical sense." (Edith Weigert in Frieda Fromm-Reichmann, 1959, p. vi-ix)

I propose, in this sense, to have face-to-face sessions without desks or anything else to separate me from the patient, an extremely important element in view, in my opinion, of transmitting a 'consistency' and a frankness, I present myself with comfortable, tidy clothing that represents me; I feel free to move between sessions, get up, I don't escape the gaze, even the physical 'provocations' or the extemporaneous requests.

> From a session with E., 13 years old, victim of school bullying (he shows up with his face made up in a disturbing way, like one of his favorite metal singers):
> Analyst: "*I've noticed that you show up with your makeup on a few times... I have to tell you that this scares me a little, it's disturbing for me...*"
> E.: (chuckles) "*Yes, because only here I can be myself, right? So I can be made up... but is it scary?*" (he seems proud)
> Analyst: "*Uhm, I understand, but you also have to know that this can distance the other, maybe you do it for this? To scare? So maybe they'll leave you alone*"

### *Active listening, even of the body*

It often happens to me, in a session, to listen to the patient's 'non-verbal' language, also through the active perception of my own bodily dimension, and then put it into context; in fact, I believe that 'references' are a fundamental tool for work, in analysis, on the body.

> From a session with E., 18 years old, restrictive eating disorder, with themes related to 'suffering' and a certain victim mentality (the patient is saying that she never digests her meals); patient followed at Rehabilitation Care Community:
> E.: (appears angry) "*I don't know, I can't digest, nothing! Everything stays in my stomach* (she painfully touches the mouth of her stomach as she says this), *but you say I have to eat, but it won't go down!*" (while she says this, a loud digestive noise comes from her belly)
> Analyst: (the analyst's belly also seems to make a digestive sound) "*Uhm, I don't know if you've noticed that both of our stomachs seem to be digesting!*"

E.: (embarrassed, giggles) "*Eh, well, yes, it's true, I hadn't noticed it before…*"
Analyst: "*But I'm wondering what this digestion is for, what is it that in the end you do not digest, because you also seem very angry… did something happen today that maybe affected you, what do I know?*"
E.: (offhand) "*Look, today I had a big fight with my mother… it's just that I just can't stomach my mother!*" (she stops suddenly, seeming struck by her own words)

## *Materials, smartphones, and 'body techniques'*

It often happens to me that I use 'tools' following a flow deriving from the current moment of consistent being with the adolescent patient (illustrated books, drawing or writing materials, books, cultural suggestions from the internet, *etc.*), also to follow their interests and languages and to 'keep together' the inside and outside of the analysis room, with a view to unity.

From a session with F., 15 years old, restrictive eating disorder, themes, including familiar ones, related to insecurity and 'not feeling good enough' (online session during the pandemic, she shows me a drawing she made):
F.: "*Can I show you something I drew… Here you see it's an eye… with a landscape inside and birds flying high, light*" (as if dreaming)
Analyst: "*Thanks for showing it to me. What did you want to convey with this drawing, in your opinion?*"
F.: (thinks about it) "*I don't know… but it occurred to me that yesterday I studied less than usual, I went out with C. and the dog for a walk, and we ate an ice cream… fruit, eh!*" (laughs)
Analyst: "*I'm very struck by what you're saying… how good you were yesterday with the ice cream… perhaps thinking about the drawing and yesterday, you felt up to being able to eat it with a certain lightness, this ice cream!*"

I also often use relaxation and breathing techniques, visualization, which I have also extensively experimented with other types of patients (performance artists; see my text *Pronti con la Voce!* of 2022), with the aim of reconnecting and delicately 'stitching' the patients to themself and their own meanings, but also to provide them with coping strategies in moments of difficulty with the symptoms, especially with the aim of transmitting the idea that 'something can be done', 'one can be with'. Generally, where possible, I also perform the 'exercises', with the aim of 'being with' and leaning on the 'mirror neurons' of modeling (Ammanniti & Gallese, 2014).

From a session with E., 19 years old, restrictive eating disorder, with themes related to 'suffering' and a certain victim mentality (the patient is talking about her recent re-enrollment at university); patient followed at a Day Care Center:
E.: (visibly shaking 'like a leaf') "*All in all, I have to say that I didn't feel anxious or scared at all*"
Analyst: "*Uhm, but I'm perplexed. I don't know if you're realizing that you're*

*shaking right now… I thought about it now that sometimes it happens to you, here in the session*"
E.: (appears impressed, shakes less) "Eh*, well, yes, I know, it happens to me outside of here too*"
Analyst: "But *I'm wondering if you're feeling a lot of anxiety right now, instead*"
E.: "*Look, I think so… but how do I know, I'm acting like an idiot…*" (giggles and shakes more)
*Analyst:* "*Come on, let's do this, let's try to take three nice, slow, and deep breaths together… then when you realize you're shaking, you can do it at home too. Breathe like this, this can send your body the reassuring message that you're calm*"

## *Holding together: the patient system and the analyst system*

As Vanni says:

> "Among the meanings that we try to understand in the consultation is that of the most relevant proximal figures. It's obviously not easy since we're certainly not talking about conscious representations but largely implicit meanings. Often better understood and evaluated by questioning the quality of the relationships (Stern's 'vitality forms', 2010) that we observe in the consultation scene or by our reactivity rather than by the narratives, more by the drawings and some tests rather than by words." (Vanni, 2015, p. 1910)

Or again, as Vincenti, Alfieri, and Noseda say, always in Vanni:

> "In general terms, understanding and explaining to the different subjects the participation of each in determining the functioning of the adolescent is a key point (Vincenti, Alfieri, Noseda, 2014). Often the symptom can be the dramatized expression of this point of individual and family balance, and the explanation of this aspect can be a very powerful lever to guide the treatment structure." (*ibid.*, p. 1498)

In my clinical practice, I look at the symptom also as a representation of the significant bonds and investments of the adolescent patient within the embodied moments, not only of individual therapy, but also of the meeting with the parents, with the entire family, with siblings, or other relevant family members. As widely suggested for the technique with young patients, the treatment scene with the adolescent has, in fact, the need to be populated also by 'figures other than the analyst alone', who, in a flexible and mobile way, always with the logic of promoting consistency and unity, are involved in the treatment path. I believe we must put aside the fear of leaving the role of the 'good analyst' and really get 'our hands in the dough of the suffering' of the I-subject that we have in front of us. It is, therefore, a question of being able to 'stay' also in the comparison with the dietician, the neuropsychiatrist, the pediatrician, the educator, structuring a multidisciplinary proposal if the

case requires it; working in a team becomes fundamental in some cases, also to convey to the other the idea of 'sewing together', that is, keeping in mind the adolescent patient in his entirety and complexity, beyond the fragmentation that he sometimes experiences.

From a family session with F., 15 years old, her parents, and the younger sister; restrictive eating disorder, themes, including family ones, related to insecurity and 'not feeling good enough'.
The analyst has never seen them all together and in person before (F.'s therapy started and ended online during the pandemic). They enter the room one by one and are all shorter than the analyst; F., in particular, is very small and petite. Only the mother is almost 'tall' like the analyst, but with the use of high heels.

From a session with the father (A.) of F., who, after his daughter's analysis ended some time ago, contacts the analyst for personal therapy (online session, the patient is in his home office):
A.: "*I admire my father… he made himself… do you see all these books behind me? There are seven, he wrote them, they are the story of his life, of how from an invisible village in the south he became the head doctor that he was*" (he appears crushed in saying this, resigned)
Analyst: "*Gosh, so many books, but how does this thing make you feel, having them there, with you in the office?*"
A.: (on edge) "*That I didn't even graduate in medicine and that my job doesn't even give me much satisfaction in the end…*" (he seems sad, as if 'disconnected')
Analyst: "*But you see, before, when you showed me the books, I found them a bit, how shall I say, 'overwhelming', as if they didn't allow you in the end to 'fly high', as in reality, A., you do in your work, but it seems to me that you don't know it all the way through…*"
A.: (he seems to perk up.) "And *then he even made a dedication here in the books, now I feel guilty. Maybe I think of my daughter F., who never felt up to it on the ski slopes… can I show you this?* (he suddenly seems cheerful) *I framed this, it's an e-mail from an important client who thanked me for the excellent work I did, I keep it here, and sometimes I look at it*"

From a session with V., now in her twenties (analysis started when she was just over 18, while she was in a Rehabilitation Care Community), serious restrictive eating disorder in strong remission, themes, including family ones, related to being 'unlucky' and suffering fate like a puppet (the patient has also scheduled the visit with the nutritionist and the internist, who are part of the 'analyst system', on the same day as the session):
V.: (appears exhausted, entering the room she almost throws herself on the analyst's chair) "*I'm tired… I can't do it*" (she seems a bit theatrical in saying it)
Analyst: "*Yes, but, V., I know that today you went all round the houses and saw us all together like when we were in the community!*"
V.: (seems to sulk) "*Yes, well, I only had today free… how would I have managed with university and everything else?*"
Analyst: "*But I'm thinking that maybe you are still attached to the idea of yourself as a sick person, that you see all the doctors and therefore can't do it on your own two feet!*"

## Conclusions

The body of the adolescent in psychoanalysis is a complex dimension in which biological, identity, and relational aspects converge. Psychoanalysis can offer a space to explore and understand these dynamics, facilitating a path of integration and personal growth during such a critical and transformative phase of life. The approach of Relational Psychoanalysis, in particular, appears suitable for working with the adolescent patient, with its emphasis on the recursive unity of the I-subject and on the direction towards an even greater consistency. In this context:

> "The analytic relationship can be described as a narrative between two people or, to use an expression by Mitchell, a 'co-creation' influenced by the present and the past, by the reality and fantasy of both the patient and the analyst. Analytic work, which certainly does not ignore individual history, cannot ignore an intersubjectivity capable of transforming both the patient and the analyst and of giving life to new relational models that are internalized and become generators of new experiences." (Lingiardi & Dazzi, 2011, p. 31)

Following the model of Relational Psychoanalysis, we can therefore have free hands in being able to look at the I-subject in its entirety and complexity and in approaching its suffering, even as a young human being, in full respect of the person in front of us, also as a corporeity. The result is certainly a fuller and clearer listening to the discomfort that is brought to us in the session by the patient, in line, as Minolli would say, with "becoming curious about their suffering".[4]

[4] Lecture by Minolli M. at the Milan Center of Italian Society of Relational Psychoanalysis (SIPRe), 2014.

## REFERENCES

Ammanniti, M., & Gallese, V. (2014). The Birth of Intersubjectivity. The Development of the Self between Psychodynamics and Neurobiology. Milano: Raffaello Cortina Editore.

Elia, C. (2013). A New Look at Schizophrenia. Milano: Franco Angeli.

Florita, M. (2011). The Interweaving: Neuroscience, Clinic and Theory of Complex Dynamic Systems. Milano: Franco Angeli.

Fromm-Reichmann, F. (1949). Psychoanalysis and Psychotherapy (Selected Papers). Chicago: The University of Chicago Press (1959).

Lipovetsky, G., & Charles, S. (2004). Les temps hypermodernes: Parigi: Grasset.

Lingiardi, V., & Dazzi, N. (2011). The relational movement. Theoretical ancestries and cultural fertilizations. In V. Lingiardi, G. Amedei, G. Caviglia, F. De Bei (eds.): The relational turn. Italian itineraries (pp. 3-32). Milano: Raffaello Cortina Editore.

Mandelbrot, B. B. (1987). Fractal objects. Turin: Einaudi, 2000, latest edition in Italian.

Maturana, H. R., & Varela, F. J. (1980). Autopoiesis and cognition. The Realization of the living. Venezia: Marsilio.

McWilliams, N. (2006). Psychoanalytic Psychotherapy. Milano: Raffaello Cortina Editore.

Minolli, M. (2009). Psychoanalysis of the Relationship. Milano: Franco Angeli.

Minolli, M. (2015). Being and Becoming. The Suffering of Individualism. Milano: Franco Angeli.

Minolli, M. (2016). What are you waiting for to leave? Love in Hyper-modern Culture. Roma: Alpes Italia.

Rosa, E., Fussi, F., Paolillo, N. P., & D'Onofrio, E. (2022). Ready with the Voice! Milano: Solos Media.

Vanni, F. (2015). Psychological Consultation with the Adolescent. The psychoanalytic model of the relationship. Milano: Franco Angeli.

Vincenti, E., Noseda, F., & Alfieri, L. (2016). Adolescent family group. Circularity of relationships and therapeutic process in Vanni F. (ed.) Psychoanalytic clinic of the relationship with the adolescent. Milano: Franco Angeli.

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