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One Cannot Touch Without Being Touched: Why Psychoanalysis Needs to Draw from the Perinatal, and *Vice Versa*

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Abstract. – There have been numerous innovations in reproductive medicine. They have led to ethical, social, cultural and medical reflections and have urged the need for a contribution on the part of psychology. The article focuses on the challenges to be faced in the mother-infant domain, centring on the wellness of working people and of the users, and provides a re-reading of the transformation processes and changes occurring in the subject who is about to become a parent, or child. As psychoanalysts and scholars, we can benefit from importing the research and acquisitions of the perinatal world into psychoanalysis since much of it analyses relationships prior to birth, albeit in medical terms. The trend that is of greater interest takes into consideration studies on the perception of touch in children, opening up surprising and fascinating scenarios. The author aims at building a bridge to connect these disciplines and create a parallelism between a certain type of touch (gentle touch) which is perceived only by the CT Fibres and connected to a massive activation of the insula, and the relationship between analyst and patient.

Key words: Perinatal psychology; psychoanalysis; neonate; parents; contact; dynamic systems; complexity; touch; insula; perinatal wellness; prevention; psychotherapy efficacy.

Over the past decade, social changes (the higher average age of women giving birth) and biological changes (the consistent increase in male and female infertility) have been accompanied by numerous innovations in pro-

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creative medicine and in mother-infant hospital wards. Specialists in the perinatal field have noted the rise in numbers of children born through Medically Assisted Procreation (MAP), the resorting to heterologous fecundation, the access to surrogate maternity, homo-parenthood, mono-parenthood, as well as the rise in numbers of pre-term births, or perinatal deaths linked to aborted attempts at assisted fecundation. The parenthood scenarios have inevitably and rapidly changed without there being corresponding changes in the juridical order (for instance, in a homo-parenthood couple the non-biological father, or mother, will have no rights on the child), or any adequate psychological reflections (Florita, 2020). The need to reflect on these issues is not a banal matter or simply a philosophical fixation; indeed, scientific studies have shown that, contrary to popular thinking, it is not the sexual orientation of the parent that is predictive of the child's wellbeing, but rather the 'legal void' that creates a health risk (UNICEF, 2014). Thus, the true danger lies in the 'void' of thoughts.

These new challenges generate important questions on what it means to take care of a subject, and how our ideas of a family and of parenthood need to be reviewed. Is the wellbeing of the mother generally part of the treatment provided by a natal centre? Does the wellbeing of a mother affect that of the future unborn child or of the neonate? 'Natural families' exist, so is it nature which decides what culture is, or vice versa? Which criteria are to be used to assess the wellbeing of the children or of their families? Can they correspond? Is the parental function concerned with gender (is there a paternal or maternal function linked to the biological gender) or with having generated (*i.e.* being biological parents)? When we speak of 'parents' are we using a term which has a strong cultural connotation, or do 'parents' exist in nature? Is it by chance that from a simple biological fact - a man and a woman have a baby - human societies do not always derive the same consequences, nor do they all postulate, for example, a 'natural' coincidence between the biological father and mother, nor do they systematically contemplate the idea that there should be two parents? Is the right to have a child an inalienable right?

Given these preliminary remarks, I personally believe that as professionals in psychoanalysis and in the field of mother-infant relations, it is our duty to avoid trivializing or idealizing or judging; we should be open to listening, try to understand the complexity of the new procreative paths, new families and their offspring, and favour their wellbeing (Florita, 2020). The wellbeing of the parental couple is a crucial element which affects the quality of the relationship as well as the affective contacts with one's child: numerous studies have shown that these are the determining variants in the configuration of the child itself (Imbasciati & Cena, 2017). At the same time, I believe that these questions, and the issues raised by medicine and culture, should become resources which enrich our reflections in the field of psychoanalysis.

I wish to leave you with some observations on the topic as well as a theoretical remark.

I will of course seek to keep within the paradigm of complexity and of the theory of dynamic systems (Thelen & Smith, 1994) since it deals with conceptualizing the process of change in development, *i.e*. the production of what has been called 'emerging order and complexity' (Stolorow, 1995): this is perfectly fitting to the perinatal area in which development (of the neonate or of the construction of parenthood) is a key element. We can study the human being just like any other living being: like every living being, it organizes itself in a coherent way since this is essential for the survival of the whole system. Thus, the unity of the subject, which we shall call I-Subject System (Minolli, 2015) or anthropological system (Florita, 2011), remains inalienable.

Let us begin with some reflections I have formulated on the basis of personal experience, of my contacts with students in the Advanced Training Course in Perinatal Psychology, and my exchanges with professionals working in the perinatal area. Immersing myself in this reality, so unlike the one found in a psychoanalyst's office, I became aware of the limits and opportunities of this world, which is governed by medicine but is extremely complex and interdisciplinary. A reality dominated by, and simultaneously burdened by, the positivistic paradigms of scientist medicine, nurtured by the constant interaction with professional figures having diverse competences and outlooks, and with subjects who communicate through their bodies, and together with their bodies (which are none other than the subjects themselves). The need to give voice to the operators and the users, and the requisite of staying up-to-date with the continual innovations in medicine and in society, have encouraged me to formulate challenges that each one of us has to face. In particular, I have formulated five of them which are indispensable to improve the quality of our work, and therefore the wellbeing of the child, or whoever is about to have a child (or wishes to become a parent). These challenges can be considered the cardinal points which help us find our bearings in the Perinatal Area in SIPRe Milan, in the mother-infant domain, a complex and apparently far-removed area from the psychoanalytical field.

1) Reflecting on the parental function and on the meaning that becoming a parent or a child has for us, disconnecting it from the biological or gender issue

Working in this field imposes recognising oneself and reflecting on our own idea of what it means to 'become a parent' and of 'being a child'. It requires us to explore the meaning we have given to these experiences, how we handle them and how they affect our lives, our clinical practice and our listening to others.

> '*In this field, parenthood and being a child have been the object of studies as well as the subject, observing - with all its a priori - the object of the studies*' (Florita, 2020).

Our being 'those' children and having had 'those' parents has contributed to laying out our own way of being, *i.e*. the coherence we have given ourselves as living systems, and inevitably interferes with our interactions with children and parents. Unfortunately, this configuration is so much a part of us that it is difficult to decipher - it is part of the work done through analysis - although identifying it may be useful to trace more creatively the trajectories of our life. Our ideas of what a parent is, and what a child is, are no doubt relevant to 'that' subject, unique in its kind, but they have also been subjected to the cultural ascendency and society's normalizing (*e.g*. each child should have a mother and a father). It is fascinating to learn how the new scenarios of filiation and parenthood (homo-parenthood, surrogate maternity, heterologous fecundation, mono-parenthood) are creating great opportunities to think differently about what it means to be a parent, disconnecting from gender, from generative function. Although these reflections are often prompted by studies of anthropology and psychology, neurosciences also help us to review our cultural a priori. Several studies have pointed out that the post-partum production of oxytocin is equal in women and men, especially when the men are involved in taking care of the neonate. Furthermore, women generally have a very high post-partum activation of the amygdala, caused by the pregnancy and the breast-feeding (Atzil, Hendler, Feldman, 2011). The massive activation in this area is linked to a primary attention towards the neonate, but it remains the same throughout the life of one's child. Indeed, women perceive the slightest mumble of their child even when asleep, and keep watch over it in a constant state of alert-care. Historical studies all showed that this area was less active in men, as if identifying the neurological substratum of the care function as typically maternal. In men, the amygdala is normally activated a quarter that of women, significantly less. But there is an exception. This pattern of activation changes if the man is, from the infant's first day of life, the *primary tutor* of the neonate (as in homo-parent couples). In this case, the activation of the amygdala is the same as in women (Abraham *et al*., 2014). Even in the absence of pregnancy and breast-feeding, there may be attention and primary care of the neonate, and this function (from a neurobiological point of view) has no gender specificity, nor is it perforce linked to biological generative function or to the genetic connection. What magnetic resonance reveals is much more than what appears, since it questions years' of studies on the father and the mother, the Oedipus complex, and so on: we realise how we have tried to enclose human functioning in a rigid framework, in pre-constituted theories, and how those theories were the offspring of our society. Feeling that one is a parent and activating the corre-

sponding functions is not a 'natural' event, nor does it depend on 'instinct': the maternal instinct is a misleading, stigmatizing concept (for those who do not feel it and build it into the relationship with their child). Moreover, if indeed a '*paternal function*' or a '*maternal function*' do exist, they would not be thought of as corresponding to the biological male or female (Florita, 2020). Birksted-Bred postulated that 'anatomy is a datum and each of the sexes has to come to terms with a particular meaning of anatomy. But how each individual deals with it is not a datum'. It is no longer possible to state that the father has the function of setting the rules, castrating, exploring, while the mother's function is to look after, to watch over, to nourish. We should not even be speaking of maternal or paternal function, but rather of parental functions in a wider sense, and we should assess them in accordance with the quality of the relationship with one's child, since they determine the child's configuration and wellbeing. In short, we might start to think that, as the evolutionary psychologist Ross Parke posited, 'the family processes triumph over the family's shape'. Our objective continues to be to assess or promote a good relationship with ourselves, as we are, and our child as he or she is.

2) Including the humanization of care in scientific treatments, on a level with medical therapy

The preliminary observation is that the 'humanization of care' is actually forcing the meaning since the 'care' as we intend it should always be humanized, because we believe in a unitary anthropological system. Care should always mean looking after the whole I-Subject, the subject as unitary, not merely having a body but being an entire whole. Care should have at its centre the relationship with the other. This forcing arises from the need to dialogue with a domain in which medicine, which takes care of the body 'machine', is the ace in the pack, both in terms of therapy and of thinking, and where the figure of the psychologist is absent or marginal. Having said that, and speaking in medical terms, scientific research has indisputably shown that humanization of care improves the prognosis. That the relation is vital and curative. For instance, when one accompanies a parent along the path of mourning for a child who is fantasised and with the anguish of death, which are correlated to preterm birth and the pain of the path in Neonatal Intensive Therapy (NIT), their presence next to the incubator will be qualitatively improved and the child will have a better prognosis. Numerous studies have shown that the presence of psychological support for couples facing fertility problems not only helps to elaborate the pain and prevent subsequent distress, but actually increases the probability of becoming pregnant (Domar *et al.,* 2000). Not to mention the importance of appropriate psychological support to the parents in

the case of perinatal mourning, or, in parallel, to the operator who, without any support or listening, is particularly exposed to burnout or the protective drift of dehumanization of care. The idea is that maternal and child centres should increasingly take care of the Subject in toto (the subject as user but also as operator), without a priori subdivisions between body and mind, and therefore not only of a component (of the body) or a desire (I'll make you have a baby), but of the whole I-Subject.

3) Avoid the spread of 'Thoughts without Thinkers' (Bion), and make an effort to establish a listening centre and a setting (a thinker) for the experiences and feelings in the maternal and child centres

This reflection, too, might be taken for granted by those whose origins are in psychoanalysis, where groups for supervision, intervision, *etc*. are on the agenda, but it is not at all banal when introduced in maternal and child centres. It is in this setting that one finds the most terrible concern - how to countenance the existence in the same room of life (and birth) and death. Yet the people involved are rarely accorded a continuative opportunity to have a space for listening, support, elaboration. In this extremely serious health crisis linked to COVID-19 and the overcrowding of Intensive Care Units, there is evidently the need for a space for listening for all the medical staff who have launched heartfelt appeals on social media and in the media for help, expressing their anger and pain. The Neonatal Intensive Therapy units are witness to this daily asphyxiating cohabitation of birth and death separated by the half-metre distance between the incubators and the cots (Florita, 2016). Yet how many of the staff have had a space for listening since the umpteenth death of a neonate in NIT? How many have been accorded the space to elaborate the passage from the omnipotence deriving from the birth, and survival, of a baby weighing 450 grams, to the helplessness and pain when one of them, perhaps even bigger, unexpectedly does not make it? And how much space is accorded to operators to elaborate, listen and accept their innermost experience regarding new scenarios of parenthood? One occasionally hears operators who - in private - express violently accusatory remarks about a woman patient's umpteenth attempt at assisted fecundation, endangering the relationship with her and disregarding the repeated failures and consequently the repeated periods of mourning. They occasionally reply sharply, expressing their discontent about that parent and that choice, a choice that they disagree with and evaluate superficially. In short, the anguish of death, the pain of birth complicated by medical problems (increasingly frequent ,in line with the increase in MAP), the mourning, the choice of techniques which are illegal in Italy but regular in

other countries (*e.g*. surrogate maternity), all involve a series of personal experiences, evaluations, and anxiety hovering in the mother-infant sectors. This not only concerns the users and future parents, but the operators, in particular. 'The true challenge is to create and promote areas of thinking, where these thoughts without thinkers, these unspeakable anguishes, may find a place and be accommodated. The moments of meeting and listening for the medical staff (doctors, nurses, obstetricians), particularly subject to burn-out, will inevitably improve the quality of being in one's place of work, as well as the medical intervention and support to the families, the wellbeing of the couple and of the future children' (Florita, 2020). Starting from the assumption that the subject is unitary, its wellbeing is not exclusively the competence of the bio-medical sphere. The moments of listening and elaboration should be considered on a par with the meetings to discuss ward matters, or to the medical-clinical training sessions, because the operators' psychological distress is fully linked to the quality of their interventions and the patient's health. Therefore, introducing a 'psy' professional, an expert in perinatal psychology, is essential when considering that the wellbeing of the subjects implicated in the mother-infant sphere (parents, children, operators) is an interdependent but necessary variable.

4) Always bear in mind that becoming a parent is very different to wanting a child, or wishing to become pregnant

One can wish for a child, 'that child' shaped by one's expectations, but one might not be ready to become the parents of the child that happens to be born, whether biological or not. One may wish for a pregnancy, wish to feel one's body functioning and generating like that of one's own mother, yet one might not be ready for maternity, *i.e*. caring for and looking after that child. These distinctions are often difficult to read or intercept in the parents' suffering, yet they are part of the travails on the path to parenthood. Without resorting to assessments, perhaps this is one of the critical aspects that surfaces most easily in subjects who have obstinately resorted to MAP and develop discomfort or have difficulty in accepting a child born with medical problems; or, in the case of surrogate maternity, the recipient parents do not acknowledge (and do not 'collect') the child born pre-term or presenting any risk of a-normalities (see the famous case of little Bridget, who became a stateless orphan because of the parents' refusal to acknowledge her). Although it is difficult to identify the impasse in these situations, it not only occurs in cases where the medical innovations clash with our morals, but also in daily living in traditional families, where distress and suffering appear linked to the birth of 'that child' and the mourning for an 'imagined child' or for a pregnant stomach. The passage from the wished-

for child, from the omnipotence of generating, to becoming the parents of a real child, very often has a mournful aspect.

> *'Pregnancy appears to be one of those moments when the deep relation between fantasy and reality may encounter notable oscillations in favour of one or the other, creating a loss of balance in which the phantasmatic aspect might gain the upper hand and consequently slow down the process of adaptation to reality. On the other hand, there may be a strong restraint of fantasies and the negation of the ambivalence which is naturally present in the pregnancy* (Ammaniti, Candelori, Pola, Tambelli, 1995).

Parenthood does not originate with biological generation (we do not remember ever having had any difficulty in finding biological parents who did not take on any parental tasks), or at the moment of birth (for instance, a father does not always feel that he is such at the birth of his child), or as a result of a strong desire to have a child; it involves a tortuous, at times mournful, process with the intermingling of phantasmatic, imaginative paths, the attribution of meanings and the passage of existential identity.

5) Include research in the perinatal area to build psychological theories on the development of the child and on psychotherapy

The Infant Research and Infant Observation centres have for years contributed to improve theories in the world of psychoanalysis and psychology. The study of the child and its development thanks to ever more sophisticated techniques and methods, has become fundamental in enriching the reflections in all fields of psychotherapy. Immersing myself in perinatal psychology, I unexpectedly came upon a vast range of studies that have been disregarded by psychoanalysis. Perhaps because many of them start with principally 'medical' issues, or are linked to the functioning of the 'body machine', or perhaps because of the difficulty in having a dialogue involving different paradigms and languages. As a psychoanalyst passionately interested in complexity, I have always paid great attention to research that has less affinity to the world of 'psy'. I have always believed that the subject, the 'I-Subject' (Minolli, 2015), is unitary - thus the mind-body unitariness is ontological - and dynamic, but also complex and non-linear, and that the dialogue between the sciences is laborious, but it allows us to complexify our thinking. The I-Subject develops through a fluid auto- and eco-organizing process. For instance, there are 100 thousand genes in our DNA, but in our brain alone there are a million billion synapses: there are not enough genes to explain the entire structure of our brain. The brain is not pre-constituted by nature except at a macro level, while the micro-functioning (synapses) is the result of primary relations and relations with the environment. The genome contributes to set a general framework of the circuits, but a detailed framework is formed also thanks to the

effects of the environment. There is no development without the interaction between auto- and eco-organization, although the changes in the living system are always autopoietic, *i.e*. produced internally by that system (De Robertis, 2005). The external does not change the subject but may 'facilitate' its movements, without directing them or orienting them as it is a part of the 'eco' relations. Within this perspective, 'also psychotherapy cannot be thought as a process of auto-mutual organization among complex systems, or as Bateson would say, a 'coevolution' between living systems' (Florita, 2012).

Having presented these brief theoretical introductory remarks, we shall now return to perinatal psychology. In the numerous studies on neurophysiology of the child, there is a leit motif which I found surprising: the one on touch. I shall try to introduce the core of the research and aim at weaving a single thread between this leit motif, the reflections pertaining to the development of the child, the functioning of the adult, and psychotherapy.

First of all, did you know that in its mother's womb, the child spends a lot of time touching itself? Yes, it is constantly touching itself, also thanks to the curled up position it finds itself in, and it also touches the sides of the uterus. All this touching appears to be extremely important for the sensorial-motorial development of the internal maps. Indeed, the pre-term babies who after birth can no longer touch themselves regularly (or be touched and contained in the mother's womb) generally tend to have more problems of corporeal perception (Ferrari, 2017).

And do you know what is the one thing a mother does most often on the birth of her child? Without realizing it, the mother spends a lot of her time touching the baby: in fact, it is estimated that at 5 weeks of life the daytime contact time is on average 9 hours and 7 minutes (N=1055 dyads) and, depending on the mother, it may even be 23 hours a day (Moore *et al.*, 2017), while it has been recorded that at 6 months it occurs on average between 55% and 9% of the time in which mother and child interact (Jean & Stack, 2009).

I do not think it is rash to hypothesize that touch is actually one of the most important channels of communication during the mother-child interactions (Moszkowski & Stack, 2007).

The skin is an organ which serves not only to protect but also in relating to one another. If we think about it, it really presents unique characteristics. It is through the skin that we most deeply feel the presence of the other (in fact, touch is one of the first senses to be activated and the last to end) but at the same time it protects us and allows us to define the borders, and sharpen our feeling of being distinct from the other. Touch is also one of the organs which most evidently contains the presuppositions for complexity: it is the interlacing between being (and self-regulation) and being in relation to (eco-regulation). In short, one cannot be touched without touching. One cannot touch without being touched.

With this preamble, we need to bear in mind that there are different kinds of contact, or, rather, of touch. And each touch, according to its characteristics, activates different fibres and different cerebral areas.

There are two large groups of fibres linked to touch: rapid conduction fibres, 'A', and slow conduction fibres, 'C'. For years we thought that touch depended only on A-beta type fibres, myelinic and rapid conduction; the thin myelinic A-delta fibres, and the myelinic type C fibres coded only nociperception, pruritus and thermoception, but NOT touch (McGlone, Cerritelli, Walker, & Esteves, 2017).

Although the connection with touch is a very recent attainment, the presence in the skin of mechano-sensitive amyelinic 'slow' (C-fibres) nervous fibres - in contrast with the 'fast' ones which in the past were delegated to the sense of touch - was found for the first time in cats, by Zotterman in the Thirties (Zotterman, 1939), a very long time ago. C fibres have been neglected until quite recently, as they were not thought to be involved with touch at all, and therefore not important.

The peculiarity of tactile C fibres (CT) is that they are not only activated by touch but respond specifically and only to gentle touch, or to put it more colloquially, to caresses. To activate these fibres and to produce the caressing touch three characteristics are required and involve temperature, speed-of-movement, and setting.

i) The temperature should be the typical skin temperature, *i.e.* approx. 32°C (Ackerley *et al.*, 2014).
ii) The movement should have a speed of about 3 cm/sec (Loken, Wessberg, Morrison, McGlone, & Olausson, 2009), not too quick and not too slow (McGlone, Wessberg, & Olausson, 2014).
iii) The final characteristic is that the CT fibre receptors have never been found in hairless skin (Vallbo, Olausson, & Wessberg, 1999), *i.e.* in the areas of the body where hair is totally absent (the palm of the hand, the plantar area of the foot) and therefore one presumes that they are only present in hairy skin. Indeed, numerous CT fibres are found in the face, the arms (Loken *et al.,* 2009), the legs.

When we are touched, sensations are normally conveyed through myelinated fibres to the somatosensory cortex. The more intense the stimulus is, the quicker and more intense the response.

Instead, the CT fibres are stimulated by the slightest pressure on the skin, a gentle caressing touch. Tactile C afferents are linked to specific areas of the brain: the insular cortex, posterior superior temporal sulcus, medial prefrontal cortex, and anterior cingulate cortex. These areas are known to be activated simultaneously exclusively by the affective touch (McGlone *et al*., 2014).

At this point, the question is, what do the anterior cingulate cortex and the insula deal with?

The anterior cingulate cortex deals with various things, including focalized attention, the regulation of emotions, and pleasant tactile stimulations. The insula, one of the first cerebral areas to differentiate itself and to mature (at 27 weeks it has almost reached maturity), can well and truly be defined a HUB for the brain. In fact, besides the social emotions, it elaborates enteroceptive perceptions.

Enteroception is a complex concept. It was initially identified as 'body-to-brain axis of sensation concerning the state of the internal body and its visceral organs' (Sherrington, 1948). As time passed and studies were carried out, one realized that this process had to be configured in more inclusive and wider terms (Cameron, 2001; Craig, 2016).

At present, enteroception can be defined as the process through which the central nervous system perceives, integrates and interprets endogenous communication, from the entire organism, and supplies an overall internal representation; the latter may be conscious or unconscious, and is constantly updated in order to pursue multiple functions (Craig, 2016; Khalsa *et al.*, 2018). This enteroceptive information, activated by the gentle-caressing touch, is both conscious and unconscious and appears to be involved in appropriating what is happening inside me at a given moment. At the moment of activation of the insula, there appears to be a real response, to 'how am I' or 'what is happening inside me' (Craig, 2016). At the peak of the enteroceptive process there is a deep integration of internal data (visceral and not), the effect of which is to amplify the sense of internal unity (Quadt, Critchley, & Garfinkel, 2018) or, as we would say, of being the 'I-Subject' at that given moment. The instant that gentle touch occurs, there is a true moment of expansion of consciousness of self (in the case of the child, it is a corporeal rough consciousness) with an increased attention and emotional regulation. Given that we started with the gentle touch and the afferents of CT fibres, it is opportune to conclude by pointing out that, apart from being pleasant, the effects of caresses in the physiological parameters of the neonate are of vital importance: they stabilize the beat, improve the saturation, increase attention. In babies born seriously pre-term, the caress might not be pleasant or re-equilibrating since the CT fibres are also immature. In this stage of life (where contact is not foreseen in nature) the immaturity of the somatosensory system might cause a feeling of continuous pain at the moment of contact. In other words, caressing is good but only when the time is right.

Let us return to the pre-term baby. As Rosario Montirosso suggests, the gentle touch promotes a

> 'level of consciousness that is more complex than a simple awareness in response to external stimuli since it provides support for Self as an entity experiencing emotions, and contributes to providing a structure - by means of neuroanatomical substrata - thereby expanding the awareness of the baby' (Montirosso, 2020).

If we think about it, we started with a physical, relational event, the touch, and spoke of a specific touch - caressing, gentle, slow, in the right place - and we are now speaking of a moment of 'dyadic expansion', of activating an enteroceptive process, or presence to oneself, by means of a relation between two beings. Now, can we provide a new answer to the question of why mothers caress their children? Because they are co-creating their body (Montirosso, 2020), and facilitating the experience of feeling the limits of one's body and self, thereby promoting the expansion of the child's consciousness, of the 'subject system' in its unitariness. At that moment the child is a bit more present to itself. That touch generates a situation of deep intimacy and it is from that intimacy that the baby distinguishes its body, feels it, feels its limits, integrates the information and perceives itself, present, in being close (but not fused) to the other.

These introductory remarks had this objective: to make us understand that in the early months of life caresses are an instrument for co-creating the child-system. The I-Subject system, by means of con-tact which, as Morin would say, is an indistinct mix of auto- and eco-regulation, has real moments of expansion of consciousness and therefore of complexifying the system itself, which develops and evolves thanks to them.

Furthermore, there is yet another reflection I would like to share.

For those working in the clinic it is evident: there are times when an interpretation or simply a word have a great effect on the other, helping them to attain a greater presence to themselves - this can be defined as a passage in the level of consciousness, a moment of intense integration, an incarnate self-consciousness, or a present moment. Those words, or those interventions, create moments of deep con-tact and intimacy, prompting the sensation of having touched the other deeply and promoting the enteroceptive process. These interventions need to have correct timing (not when the time is premature or at 3 cm per second), the right warmth (32° which is the body temperature), and should not occur when the patient is bare (on skin that has little hair). These are moments when one touches and, at the same time, just as with the skin, one is touched. They are small miracles, which promote expansions and emerging properties of complex systems.

Perhaps in those intimate moments the insula is activated, perhaps the presence to oneself is actually concerned with this somatosensitive process, and perhaps, if we could look inside the brain, we might discover something similar to what happens during those gentle touches. Perhaps the key to reading the characteristic of those interventions is to see them as unique moments of contact, in which words have a partial weight unless included within the intimate atmosphere between bodies, which arises only at the right time, in the right place, at the right pace, and with the right warmth. Perhaps they are moments which describe and narrate the setting up of a deep relation because *the quality of the relation* between the thera-

pist and the patient (as well as the duration of the course, *i.e.* >1 year, more than 50 sessions) is the most important therapeutic factor in psychotherapy, beyond the theoretic orientation and the techniques used (Baldoni & Campailla, 2017).

If we consider this parallelism, which might be hasty but is undoubtedly poetic, it brings to mind how important these intuitions are in perinatal psychology, in the relations with the other and in psychotherapy. Never touch the other when their skin is too hairless; the other should feel that they can defend themself even simply thanks to the hair on their skin, to avoid feeling that closeness and contact as threatening. We should not be too cold, like a grey screen, but we should not be too warm either, or dramatically engaged; we should reach the 32° that allow us to feel the body and the person as the other, because it is only in this way that we attain intimacy. We should choose the right time, we should not be in a hurry, nor should we be too slow, the timing of con-tact is fundamental, it is the effect of a contemporaneity of right moments for both the subjects involved. Each subject is an individual, some have less hair in a certain area, some in another; some cannot be touched on the arm because that is where they are sensitive, some prefer the leg; some prefer using their right hand to caress and some their left, there is no equation to recreate the pleasantness except to accept our uniqueness and that of the meeting of two skins. It is only in this way that we will promote the enteroceptive process of presence to oneself, and we shall help the other to feel themself and to integrate, at a higher level, all that is happening in that I-Subject at that given moment. Whether we are dealing with a patient or a child, our presence should not aim at changing the other; our presence should be gentle and respectful, with a patient as well as with a child, because it is only in this way that the other can fully understand themself, their borders and their resources, and improve the quality of their relation with what they really are.

When touching, one cannot help being touched. Because it is only by being there, by being in contact with ourselves as we are, making ourselves feel human and warm, present, measured and respectful of defences, that we can help the other to be in more or less conscious contact with themself, to integrate internal information, to determine their borders and limits, and to move more freely and creatively in this world. Truly, a miracle.

> '*An intimate conversation with a person who is dear to us is, I believe, one of the greatest* pleasures *life gifts to us. But in order for such a conversation to take place, one needs to have a partner who knows how to listen, and at the same time to confess. Who knows how to be frank, but* not *wishing to be* hurtful*. Unpredictable but not menacing. And, of course, one needs* time*. Both parties need enough time to move into the depths. And a* place *is essential. Which allows all this to happen.*
> *In short,* truly a miracle*, which only occurs rarely*'.
> (E. Nevo, 'L'ultima intervista').

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