*Ricerca Psicoanalitica* | pISSN 1827-4625 | Year XXXIII, n. 2, 2022
*doi:10.4081/rp.2022.666*



# Interview with Corrado Pontalti in conversation with Fabio Vanni[1]

*Corrado Pontalti*, Fabio Vanni***

ABSTRACT. – In this conversation we touch on issues that are currently at the heart of the debate on psychological therapy. From the stimuli generated by subjects and their relational profiles in the current request for consultations, it seems opportune to create an updated vision of the relations between the family and 'Western' society. Pontalti also puts forward options that he considers are an appropriate response to families' demands for therapy at the present time. The conversation also includes education, forms of parenting, and the consequences that these theoretical and clinical options have on the training of psychotherapists today.

*Key words*: Clinical psychology; complexity; families; sociology; history.



Fabio Vanni: I am pleased to have this opportunity to talk to you, Corrado, whom I know as a person that represents a bridge between psychodynamic and systemic-complexological knowledge, and between theory and clinical complexity in humans, and I believe you can give us, here, today, food for thought which combines divergencies and correspondences. From what I have read and from what I know about you, your attention has always focused on real clinical experiences, and on more challenging situations, which, although more frequent in the public sector, are nevertheless present in therapy - unless they are consciously avoided - and may be found in various places and on various occasions.

Today's meeting seems particularly promising given that the focus of the Journal

*Psychiatrist and group analyst. Retired Professor of Psychotherapy at the Policlinico Gemelli of the Catholic University of Rome. He was head of the Family Psychotherapy Service of the same Institute. Past President of C.O.I.R.A.G. and the Gruppoanalisi Laboratory. E-mail: corradopontalti@gmail.com

**Psychologist, psychotherapist, Director at AUSL Parma, RP Director, Scientific Director of 'Progetto Sum', Italy. E-mail: fabiovanni@progettosum.org

[1] The conversation with Corrado Pontalti took place online on February 4, 2022, with Elisabetta Lepri - whom we thank – and who subsequently transcribed the recorded text, then reviewed by the participants, and finally translated into English.

is precisely how therapy acknowledges and allows for the complexities of human beings and their relationships - which may or may not be more complex than they used to be, but which are now certainly complex for various reasons.

So, I think this is an aspect that we can profitably discuss. Maybe you would like to say something about the theme that I have broadly outlined...

Corrado Pontalti: First of all, thank-you. Every exchange of ideas enriches us, even more so if it involves people who work in the public sector as you do, and which I do, although more indirectly now. It is always a precious opportunity.

Maybe you could set the ball rolling by giving me something tangible to work with - aside from the theory - that could also help us to think about some practical applications in clinical practice.

FV: Perhaps clinical practice could be our starting point.

Clinical practice has always offered, and still does offer important stimuli, the opportunity to understand what constitutes human beings, how they relate to others, how they feel around others, and also the forms of difficulty, discomfort, and suffering they experience today, forms which are in some respects very different from those of other periods. This solicitation has often been constructive but in the past, there have been forms of entrenchment in defense of theoretical models, in defense of perspectives, and even in defense of a technical order seen as somehow untouchable.

It's like saying: "Either you see things my way or you can go hang!" This is putting it rather bluntly.

As well as being unproductive for the discipline and the theory itself, in terms of knowledge, this attitude is ethically questionable.

Today, for various reasons, this is less common, or at least it is less evident, for reasons that may be quite unnoble, in the sense that there is more competition nowadays and we need to stay in the market. However, there are many other reasons why this is less common, among these the fact that malaise was interpreted in many different ways during the 1900s, suggestions were put forward to find new ways of thinking about subjects and their relationships, and how to intervene therapeutically.

One of the meta models, or the underlying principles that are used to unite these different perspectives is that of complexity of thought, and therefore of systemic thinking; but also of group logic, which belongs to another type of tradition with affinities and functionality in reading the relational aspect of humans and it can, I think, provide a useful perspective.

Meanwhile, I wonder what your thoughts are on this.

CP: It seems to me that you have put your finger on a particularly significant aspect, that is, clinical practice as an means of opening up to broader vision, a very effective perspective in its simplicity.

A problematic situation comes to your attention and in some way speaks of

something; this something is what constituted a step forward in thinking from Freud onwards. The world did not begin with Freud, but I often think that Freud lived in a particular circumstance: in other words, in the Vienna of the time, a girl alone, a young girl, or a young woman in distress could leave the family and go to a doctor's surgery, is something that was unthinkable previously given the socio-anthropological constraints.

Freud was able to study the emergence of the individual construct in Western culture, which is simply the personal construct with citizenship rights.

You'll say that I am going back to the dark ages.

Aside from studying the thinking and history of the psychoanalytic movement, psychoanalysis historians have been my guide in approaching this aspect, which, in some ways, already represented a broader scenario than Freud's clinical narratives; clinical narratives that may be seen as the product of a certain period, an era, and, therefore of a culture, a society, a social class, of human groupings with precise codes existing in a particular historical period, and an event that can come to our attention.

There is little doubt that the strong sense of belonging to the traditional family of previous centuries would not have allowed for the possibility that a person, a female no less, could cross the boundary into a territory not under the control of Family codes.

But this story began with the Enlightenment, the French Revolution, and the struggle for votes for women.

I have always tried to understand whether therapy could also have arisen as the result of the contemporary world making therapy accessible.

If we wish to follow this line of reasoning, we should mention that Freud had access to the narration of these clinical stories, and in some way to the data, emerging in therapy, that sexual abuse took place within families, and to the symptomatic reactions to that abuse.

What was the problem? It was unthinkable that the Viennese bourgeoisie family could be challenged. Unable to explore the family tissue from within, Freud had the most brilliant and radical intuition of his career, and of all subsequent psychoanalysis, that is, the mind is in some way an operator of transformation, not simply a carbon copy of what happens.

Socio-anthropological signifiers made the family environment, in relation to family narratives, unexplorable. The signifiers changed during the course of world events, and after the Second World War movements arise in the United States, but quickly spread in Italy, too, called 'The World of Family Therapy.'

Then, one might ask, "How is it possible that the family came to the forefront, and, through therapy could make a contribution to analysis, intervene, and possibly provide inside knowledge?"

Keeping to this line of reasoning we can see that our profession and our knowledge convenes around the areas that a historically determined society deems to be fragile. In addition, in our collective imagination the Family has emerged as a place of fragility in the ensemble of socio-anthropological dynamics.

And here, in a way, is your appeal to complex thought: in complexity and multidimensionality as a whole, and in the discontinuity between the areas of a Societas and society, there is always a fragile residue, which through the ages, and even today, is consigned to the sacred, religious, shamanic dimension, that is, to the epistemology and management of agencies delegated to the confines between what is knowable and comprehensible, and what is considered disturbing and mysterious, or the bearer of Mystery.

Freud's girl was disturbing, the family came to be seen as disturbing after the Second World War in the West, and I stress in the West, because for 80% of human history it is not thought of as disturbing, not even today. We see this with migration and globalisation. In many areas of the world, in many populations, what those cultures call family is not perceived as fragile, but as the governing force of the codes of existence.

In our Western culture, after the Second World War, the family became a fragile institution for a number of reasons, and for two in particular.

Firstly, there was a progressively radical localisation. In 1948, when I was six years old, 80% of Italians lived in the country in an agricultural-farming-pastoral setting. This meant that 80% of the population had the support of a local community, the anthropological community, which acted as a safety net, and if Elisabeth remembers her grandparents' tales, they are descriptions of another world. So, talking about and talking with one's grandparents means that, despite one's youth, one is in a narrative where one's sense of existence is dependent on belonging to the local community, with its rituals, its traditions, its economy, its codes, its generational transmission of knowledge.

Thus, the solidity provided by localisation and consequently being anchored to a basically stable, self-contained world, ensured a certain representation of the family by the community.

Mobility and in Italy, internal migration from Sicily to Piedmont, from Veneto to Turin, from the Marche to Rome, this great reshuffle, which also occurred in other European nations, not only in Italy, deconstructed the security of the community and its customs which passed on the norms and internal rules of families. The family was not represented by a father, mother and child, the family was the community. As Lèvi-Strauss taught us, marriage is a marriage of communities, not of a man and a woman, but of communities; the man and the woman are an *accidens*, so that the love theme was irrelevant: "A good girl, a good boy, a good worker, a good housewife, we have known the family for four generations..."

Social codes were very strong and clear; they have grown weak due to the nuclearization of the family community which from being a social community has turned into a relational community.

The family became fragile, lost and small; it became lost and small because it lacked its traditional codes of behaviour. Interestingly, what developed at this time?

Family Therapy, as it is commonly known, developed at about this time. But what interests me is that we approach clinical therapy because at an individual level,

or for an institution like the family, or in other areas - today it could be adolescence during COVID - they are perceived as the bearers of fragility, even though they were not formerly perceived as such. This fragility becomes disturbing, it concerns and worries Society.

If we take your idea, which I made a clumsy attempt at summarising, further, what presents itself to us is a limited request: it may be a patient, a parent, or two parents for a teenager. This can become an observatory. We can try to expand our positioning and understand the socio-anthropological background that it comes from and that it refers to.

I totally agree with you that clinical psychology is a great opportunity to open a window onto a period in history. Clinical psychology, however, risks a paradigmatic bias, in other words, we might isolate that request and think of it as specific to that person and that family, and fail to thematise the structural characteristics and difficulties which characterise a particular period, in a given place.

Therefore, that variety of approaches to which you allude has no place in a complexity paradigm, instead, it almost always manifests itself in the absoluteness of one's own interpretation and procedure. Complex thinking does not allow for an excessive variety of points of view, because if you multiply the viewpoints, you shatter the complexity paradigm; you generate a series of islands where each island is no longer in a representative relationship with the whole.

Increasingly, after the war, and after 1968 and all these great transformations, clinical psychology comes to treat each person with a mental issue or, more radically, with a psychopathological condition, has an autonomous level of mental organization signalled by the 'generic' paradigm, vulnerability-stress-trauma

The extent to which you associate the fragility of the personal with the fragility of the familial, the pathology equation and the intra-family cause of the pathology becomes a sort of final synthesis for which the family has been extracted from the social context, and has become a sort of nativity scene, a mother, a father and a child, and the destiny of the second generation is the consequence of how this mother and that father act with the child.

Complexity has become a despairing, increasingly refined simplification where one's destiny hinges on the mother-child relationship.

What do we conclude from the many therapeutic failures that we must overcome today?

We must, no matter what, free ourselves from the ontologising of the family as a fairy-tale entity: mother-father-child; we must totally abolish this still predominant representation that the dice are cast for good in the early mother-infant relationship. The first paradox is that scientific literature, sociology, and anthropology have, for forty years, been "searching for the Father-father".

Obviously, it is one thing to say the father is the third character to appear on stage, and this was fine for the anthropological organizations of Freud's time, or at the time where I was born. It was obvious that the world of men and the world of work took over at a certain point in life, but it was not a question of where the father

was, or the mother as we imagine her. So, then we search for the father: a pale father, a lost father, a father on the side-lines, father here, father there…

The disarticulation of the family from a community and from local ties is a past situation that we must take into account when attempting to change our paradigms.

In fact, if we limit to this micro-environment the community where the adventure of human existence, the formation of the human mind, and the growing person's sense of self is established, the complexity of the variables in the field collapses into an insignificant reductionism. In this configuration a sort of sacred mythical figuration emerges: mother-newborn-child, or, at most, the ontogenetic founding triad, mother-father-child (the mythemic ikona shows neither siblings nor grandparents).

It is the language itself that helps us understand how we reify the aetiology, 'the rigid family, the symbiotic family, the symbiotic mother, the absent father": the use of negative connotative adjectives means that in the face of the challenge that clinical practice poses in attempting to understand the world, the stratagem of using our know-how isolates the clinical scene from the world and we behave as if it were the world.

This led to coherent treatment plans: How do you proceduralise child psychoanalysis? Start by taking a child or teenager, you remove them from their pathogenic family, you have five sessions a week, you neither wish to see nor hear the parents, "Go to someone else for treatment." So, I uproot the child, who I believe is the bearer of the whole truth, not the present truth, but the essential truth of their existence, and it will be just me and the child, "You parents have problems - go and solve your problems somewhere else; your problems are the cause of your child's problems. I'm your child's therapist and you may not speak to me!"

We surely recognise this scenario since we are talking about the last thirty to forty years. It proved not to be very effective in child psychoanalysis; obviously, the disarticulation of an already small universe means that the therapeutic field is insufficient!

Therapeutic systems that operate in isolation are not a window onto society, and therefore to the historical period, nor to the sociological, anthropological and juridical characteristics of society. These are variables of the collective imagination that generate constraints to mental development, and act as structural signifiers. Religious systems, in every age, seek to define the form of the 'natural, God-given family'. It follows that the family is disarticulated by history, it is not conceived as the institution of a historically derived society. It is the complexity of a society that determines the tasks and horizons of the family. Therefore, the 'good family' configuration is historically defined, just as the representation of 'a good mother, a good father, a good relational field'.

We have little understanding of the transformation of social and psychic signifiers, because for the village societies it was clear that you could entrust a child to a mother, an aunt, a sister-in-law, an uncle and so on, it was determined. A girl of four or five would take some responsibility for a new baby, she would learn how to

take care of it; a seven or eight-year-old boy would learn how to take the sheep to pasture - this is the story of my own childhood - everything is clear and closely linked to the operational dimension of life.

What has happened in these forty years to arrive at a situation in which no-one is entrusted to do any operation or task and the only mandate is psychological well-being, the 'non trauma!'?

In 1989, the Universal Declaration formulated a new mantra 'In the child's best interests', which concerned the child's psychological dimension, it does not say "It is also in the best interests of the child to learn to plow the fields at ten'. If your five-year-old child washes the dishes, the Social Services intervene; I exaggerate, but not too much. These children, those a little older, then pre-teens, and teenagers, and young adults are never ready to take on responsibilities within the family, for the family, for the home. There is a classic scene, in the house of friends with children, or in my house with friends with children: the son, who is not exactly in nappies, says 'I am thirsty' and the adult sitting at the table gets up and brings him a drink: if I say: 'Excuse me but doesn't he have legs to go and get water?' They look at me as if I were an alien. They say 'Poor thing. He's tired'. Tired of what??

Listen to what people say... about the High school diploma): "Poor things, they have to do the second paper for their 'maturità'.".

We need to ask ourselves why the pact that bound generations to the acquisition of the operational skills necessary for family life and the community has been broken. At the age of 6, I walked 3 km to get milk. Nowadays, can you imagine sending a child to the shop next-door to do the family shopping until the age of 18?

PV: it has become dangerous in the collective imagination.

CP: Yes, but why? It is the collective imagination that considers directives and the awareness of directives, so that it isn't that parent who thinks the child is inept; the parent senses danger because the entire collective imagination considers that it is dangerous. Obviously, this proceduralism becomes recursive. When I was a child, the collective imagination did not consider that my going somewhere was dangerous.

And why is it considered dangerous? Because of the profound changes in the family-society pact.

Up to the famous 1960s when people began leaving the countryside, the family was only a functional piece of the fabric of the village, the community.

Now, family and social settings are no longer a unit or attuned, they exist in discontinuity with an important hiatus. Once, the equifinality of the family and community setting was to make the child citizen effective and efficient in the local community, and from there to the supralocal communities.

No one was concerned that the child was serene, that he did not suffer, that he did not cry, that he did not protest. This emphasis on psychism was neither foreseen nor mentalised, nor manualised. Because psychism was the way you adapted to the community. Over the last 40-50 years, in the Western world, the Family mandate

has been to take care of the psychism of its few members. To a large extent, social education agencies (nurseries, kindergartens, middle and high schools) are also entrusted with this important focus. Let's also reflect on university constraints. You can be a university student forever without making any steady progress in your studies, whereas, in most universities in the world, if you do not progress you are expelled. Here another important question arises: How do we signify the phenomenon of adolescence; a new invention with respect to the construct of puberty. It is a true latency stage: together with complex and iridescent phenomenologies, it occupies the hiatus between the two settings.

Clinical psychology, therefore, would allow for continually evolving heuristic insights, unless it chose to isolate the phenomena, and to seek traumas and culprits.

FV: You are presenting a very interesting perspective because you go from the general, from the historical-cultural dimension of individuals to the experience of an individual.

This runs counter to what often happens, where we reason in reverse: we focus on the subject in much more general terms, we seek a broad model for the subject, and we endow considerable centrality to this option.

After all, the most famous therapy, therapy *par excellence,* is individual therapy. The couch is the butt of jokes, and best represents the collective imagination.

The prevailing idea is that contained inside human beings is a way of being in relationships which comes from their relational history, starting from your relationship with your mother and, depending on how that experience played out, certain difficulties, complications, or at least, some of the characteristics of your character formed.

This is the classic narrative, and it is as though therapy recycles this story, because if the essential element of the subjects' constitution is the mother - child (or caregiver-child) relationship, I, as therapist, propose a revisitation of the subjects' relationships, in other words, I will try to attempt to restore more adequately, some forms of relationality.

Of course, one could legitimately defend this perspective, that I have only outlined here, but I am more interested in understanding something that will help us better understand your way of thinking.

Your vision implies consequences, in the sense that it implies a form of intervention which you could maybe explain further, as I also recall some of the things you wrote. I really liked the concept of "chorality"; in one article you wrote that you didn't understand why, if this is functional, we are unable to approach therapy through different choralities or different interpersonal configurations, if this is practicable.

I'd like to know how you translate this vision clinically?

CP: Some scenes are stuck in my mind. It was maybe seven or eight years ago: in a clinic a young female intern specialising in psychoanalysis describes this clinical

practice scenario. She is working in this clinic and a serious case comes in, a fourteen-year-old girl, but she cannot understand the problem. I ask her what I think is an obvious question, "I'm sorry, but she can't have come alone …?" And the reply: "No, her mother was there." And I say: "If you couldn't understand the girl you could have spoken to the mother, right?!" The girl looks at me and says: "But I'm not a family therapist."

So, the challenge presented by your initial stimulus is this: that it is not necessary to be a family therapist or have the technical-procedural equipment of an assault troop or marine raider to talk to a mom or dad. By this I want to point out that reflection you just made creates a confidence boundary so that whatever is beyond that boundary is the enemy and requires special instruments. In fact, what we are actually doing is addressing another human being; if you cannot understand what the daughter is saying then ask the mother and this will help you to make an initial evaluation.

PV: The main approaches to professional training still tend to teach a certain order: individual, family or group. Never or almost never are we trained to operate using different perspectives on treatment and even less a combination of them.

CP: Absolutely. I was teaching in an important school of phenomenological psychopathology, and although it was a phenomenological school, everyone was stuck in an individual mindset; the banality of being able to talk to the mother was shocking to them, and this was last Saturday. So it is still generally taught. The students look at you and say: "But if I'm being supervised and I say who I met I'd be lambasted!".

That's the way it is! Even today!

Another scenario I like describing took place in another Clinic - these themes are particularly relevant to us because we both deal with adolescents and you have always worked with them: a mother and daughter arrive at the centre and they say to the psychologist who receives them: "We have a communication problem." The psychologist tells her: "Very well, then. I will make you an appointment to see Dr. X on Friday, and you can see Dr. Y the following Tuesday." They look at her and say: "But you have totally misunderstood, our problem is communicating with one other." And they leave.

And we are not talking about the Dark Ages here, either.

FV: Yes, this seems to be the norm in psychotherapy training in our country. It is also interesting for our young colleague, Elisabetta, who is perhaps thinking about undertaking psychotherapy training. It is a criterion for selection.

Finding professional training that equips you to consider different ways of looking at humans and human relationships is no trivial matter. I must say that the single-structure model is less widespread in psychotherapy training for children and adolescents where working with the individual and the family seems more common.

However, the group approach remains less common as a training option. Your proposal means making a significant change in the way we think about consultations, at least, at the initial listening and analysis stage of the request for therapy and leads to a shared plan of intervention.

CP: The first stage of an encounter should be based on an awareness that the situation is totally unfamiliar to us and that the symptoms are so overstated that they are often misleading. The first encounters are the reification of the paradigm of complexity. This is even truer in adolescence where the symptomatic and existential precursors are organized, and where, if they are not 'healed' , they pave the way for years of psychiatry and chronicisation. The stages of this fate are well-known: drugs, day centres, a series of therapeutic communities, and after 20, 30 years they end up in a long-stay clinic, or, if they are lucky, in a group/foster home.

Therefore, in this area we have a great responsibility. We really do have to think in terms of community, and in these times, the family community. And this calls for an alliance with the people who are part of that community to which, of course, our patient belongs. Founding that alliance is a radical part of the project, but we must change the way we see that community. If we think that the mother is schizophrenogenic or that the parents have sabotaged our splendid therapeutic pathway, we will fail to recognise the deep, personal knowledge that the parents can offer, and the fate of children and adolescents with severe psychopathologies, will be sealed.

FV: I'd like to examine this further. Could you share more of your thoughts? What method or criteria should guide a clinician skilled in using various therapeutic procedures in complex situations? Maybe in dealing with schools, communities, etc. How do you, personally, manage this aspect? What would you recommend? What do you think can be done? And how do we train our young colleagues?

CP: Let's start with complexity. We need to be skilled in the configurations that I have put forward, and to bear in mind that School, as an educational institution, is affected by the same transformations as that of the collective imagination. Every difficulty in adolescence in the educational field results in a diagnosis of SLD (and, with rare exceptions, the battery of tests are self-fulfilling prophecies) which leads to the creation of personalised and facilitated training programmes that take the child through school to university. The clear message here is that to follow a normal educational path would be traumatic for these students because of their fragility. This year, I was struck by the fact that, for the High school diploma, headmasters wrote a letter in favour of a single written test and not the usual two; they claimed that two tests would be too anxiety-inducing, given the lockdown.

These considerations derive from a historically determined collective imagination which establishes harmony between institutions that represent the child and adolescent as fundamentally fragile and instantly injurable.

I acknowledge that the 7, 12, and 15-year-olds are not the ones who call you or the Social Services, it is always a parent who acts as mediator, exactly as is the case,

in my experience, with adults. Even with very complex conditions, even in adolescence, or with young adults, it is not the patient who calls, it is always the caregiver, someone in the adult-parental world.

So, precisely because I know that I know nothing, the first thing I say is "Please come and help me understand the situation." They say, "But my son/daughter wants to come!" And I say "I am very happy to hear it. However, it would be good for us to meet and get to know each other. You can give me wider perspective." So I try to I try to firm up the picture because I am convinced that they have knowledge that I do not have: they know things, they will know them in their way, but they know things that I do not know. Therefore, concerning complexity is also the fact that complexity - as stated by Ceruti - is accompanied by the fact that you are constantly on the edge of something unknown that you are going to explore.

I would suggest and recommend that you start with a framework, and you can only get the framework from older people, from the generation that witnessed the birth of the generation I am going to talk to; it is not the search for a narrative truth, it is simply that I need their help to get a rough idea of what the situation is.

It is important to make these assumptions because if parents are questioned as bearers of knowledge that you do not have, they are unlikely to feel threatened. It is different if you say to them "I am going to start with you." or "After three or four sessions with your child I will meet and get to know you, the parents." The message is very different: "What will our child have said about us?" Of course, they would be critical, otherwise they wouldn't be teenagers?!

They are, like all parents, condemned. It is the collective imagination which we spoke of before which entrusts to them the soul of the next generation, as if they were God: you are the *maieuti* of this child, so every failure is seen critically on the part of society and causes guilt on the parents' part. It is commonplace for parents who feel judged, to react by tearing their clothes or by attacking the interlocutor because they have been attacked or because they fear being attacked. It is a commonplace consequence of their relationship with the world of psychology.

If, on the other hand, the parents are my first port of call, I immediately convey the message: "We have a problem that we must tackle it together, and you know more than me." It goes without saying that they know more than me; they have lived with the child for seven, fourteen, sixteen, seventeen years ... whether they know the child well, or badly is based on how I want to interpret this knowledge, but they still have it. I may not be able to help thinking "You are wrong. I can tell you what is right." The implicit message is very powerful: "You are wrong. I know how mothers should behave; I know how fathers should behave." Just think, parenting courses are generally conducted by young psychologists. One day an intelligent lady asked: "Excuse me, Doctor, how many children do you have?" And she replied, "None." And the lady said: "Well, how the hell can you tell us how to be parents?!" I am obviously being trivial. I know that courses, and group work can be very important for sharing problems and methodologies. But my job here is to point out the implicit codes that can sabotage therapeutic work.

You need to play your cards right at the first meeting, because although they arrive together it is usual to tell the lady to wait in the waiting room, or suggest she go for a coffee while you talk to her child, or "Well, you came together so you can come in for ten minutes, but then please leave so that I can talk to your child."; the negotiation, or the way we organise this first meeting - on the threshold - determines the fate of therapy.

I have no idea how they imagined the meeting; so, I cannot decide... I hope this gives you some idea about the first organizational move.

FV: I do it differently. I say, "Who would like to come …?" And I dedicate the first part, the first meeting, but sometimes more, to whoever would like ...

CP: Yes, that's a possibility. It is certainly different from saying yes to one, and you don't want the others, but based on the general reflections we made before, I would be concerned about communicating a message of competence. I don't know what group dynamic might unconsciously be activated in a family group at the words "Who would like to ...?" I don't know if the one who comes is the designated spokesperson, or if the one who comes will lead me in the wrong direction; I don't know where this "Who would like to …?" will take me and this is worrying because I find myself, through saying, "Who would like to" having to deal with a group dynamic, maybe a contingent one, but one whose composition I am ignorant of. This is just a reflection on what you said about how you act.

FV: It seems to me that what you are saying is also very relevant to another matter, in other words, our therapeutic work. If you think about psychoanalysis, it began with adults, even though the Freud's hysterical patients were little more than adolescents, and sometimes truly adolescents, but to all intents and purposes at that time were considered adults. Further, psychoanalysis began with the Freudian idea of reconstructing, through therapy, a history of the child with all the complications, even epistemic, that this involved.

For a long time, it seems to me, the psychotherapy clinic has had that kind of image: something that concerns two people - basically adult to adult, while recent decades have seen a reversal for which, although there is still a demand on the part of forty and fifty-year-olds, there has been a sharp increase in the demand for child and adolescent therapy also for the reasons you mention: a representation of the fragility of childhood and adolescence determines the fragility itself. The fact is, however, that there is a huge demand for that age group, which is supported by schools for many reasons, including delegation. On the face of it, the object of the demand is the child or adolescent, but it is more complex than that, and if I understand you correctly, should be dealt with in terms of complexity, and definitely not by instantly unpacking the demand as this would be reductionist and a simplification of the complex which would lead to a considerable and decisive loss of information.

CP: I totally agree, and I apologise for the coarse way in which I treated points which deserve a more in-depth analysis. Society's mandate is that we must not cause young sapiens any psychological damage. It is a negative mandate about what you have failed to do for his well-being, and the parents' question is: "Yes, but what shall we do?". The fact is that we no longer have access to the stratified, sedimented, automatic knowledge that was passed down in those conservative villages and local communities. If we, as practicing psychologists, are aware of this 'not knowing', the paradigm turns full circle. "You don't know, I don't know, we need to find the solution together, but no one has it *a priori*.". The educational commonplace of families, schools, the community, of the new generations has gone. It was an educational commonplace for my teacher to rap my knuckles with the ruler if I wrote badly, and no one thought it was traumatic, and if the teacher did not do that, she was a bad teacher; if I got four (out of ten) in Greek, my problem would not be that I only got four, but "Oh no! What will my father say?". And my father reprimanded me, not the school, as is the case today.

This consistency acted as an anchor for symbolic and procedural knowledge. I have no nostalgia for that time except as a memory of my life. I study how the codes of signification change with the times; I assume that knowledge must change; I have learned from many, too many of my clinical failures, that procedures are not predetermined, but determined by the individual situation and clinical setting. Thinking in terms of complexity is a painful discipline; it takes time and skilled masters. Our perception is more often not of complexity but of confusion and bewilderment. The most spontaneous simplification is the identification of a linear cause, which in psychological terms translates as a search for parental deficits, and this is amplified, sometimes paradoxically, into a search for the trauma construct. It is emblematic that on lifelong learning sites, webinars with the word 'trauma' in them are very frequent (almost 90%) - and so are the corresponding therapeutic techniques! Everything has become a trauma. As a referee I read this from an article: "In the patient's home people spoke too loudly. TRAUMA! Therefore, the therapist must speak softly." Well done. Article rejected.

Today, the least desynchronisation between the mother and the child is enough to generate trauma: the child looks at her expectantly and the mother looks guiltily away; she is not synchronised ... (these threads are repetitive, like mantras, and appear in much scientific (?) writing which is easily available today.? What about having synchronisation workouts! What can I say?!

It is interesting to talk to young mothers who have been thoroughly indoctrinated. They say, "Me and my baby, we must live in a bubble for months." Live in a bubble ... skin to skin, with milk, in a bubble!

Okay, live in a bubble, if you want!

PV: In this case the therapist takes on a different role...

CP: Of course! Teenagers' parents say: "Professor, give us the answer." I say,

"Excuse me, I don't have a clue what to do with my own teenage children to be honest, and you expect me to know what to do with yours?!" All I know is that we can try to figure this out together, together with you, and with him, finding where the tangles are that block our search. This is why I am unable to propose an *a priori* therapeutic plan. I begin by exploring, and then I decide whether the situation is condusive to working regularly with the adolescent because he is mature, shows some initiative, can act autonomously, can manage pocket money *etc*., and from time-to-time talk to the parents. If construction of fragility and 'spoon-feeding' are characteristics of the family story and are ingrained, I will need to work with them to weaken the intensity of their caregiving, so they can process the fact that setting a teenager tasks and limits does not mean not loving the child, and neither is it a trauma. I'll say, "What about getting the boy to make his own bed?" Male or female. They say, "But he won't do it." And I say, "Ok then, leave it unmade." And they say, "Oh no! I can't do that. Poor thing." The idea that everything is a trauma deprives the child of the skills to manage routine tasks of daily life, and the family's corporate life. Tell me, how many colleagues do you know who investigate psychic trauma rather than how the family business is run, *e.g*. who washes the dishes, who sets and clears the table, who loads the washing machine, who loads the dishwasher, who goes to the shops to buy ham, and who goes to the bank to pay the bills. It is not on the cards for the zero to 20 generation. You have to work with them for a long time to change their codes of caregiving and substitution because you have to go against the collective imagination.

I say to trainees: "Go to any supermarket, you'll find moms with children, dads with children, grandparents with children, you may find 22 or 25-year-old adults, but you'll see no-one in the 12 to 20 age range shopping alone. A simple sociological observation. And if you tell a teenager to go, then the supermarket becomes a jungle in the teenager's mind and he gets lost in an authentic sense of dissociation."

Of course, this dimension isn't "I know what you must do." but rather "I need you to help me build a method." So that you can see your child as not so fragile, and able to complete tasks, and thrive with less caregiving.

FV: But what I also think is important is that as a therapist I need to be equipped to offer different solutions, use different approaches, and not have just one string to my bow...

CP: And also to use different formats - it may be right to see the patient alone as a rule, but something might come up that suggests that the father and mother differ in some way. There may be a dimension that concerns the patient's relationship with the mother more than with the father. In that case we will arrange to have some sessions with the mother, and then we will have one altogether. It is important to hear you two siblings... how many breakthroughs have happened just by bringing siblings together? In general, the configuration is father-mother-son/daughter, the other children are kept out of the picture, or are included necessarily in family therapy. Here it's "Everyone come along."

However, we need to investigate what can be generated from this intersecting, and we can only do that by exploring. Clearer scenes will emerge and we can attempt to simplify them a little by interacting with a subset of complexity. Since it is mobile, and not isolated, or bound to *a priori* procedures, it comes under complexity. If I isolate it and make it into a "We will always meet like this" it cannot come under complexity. With the complexity paradigm in mind, I can activate a sub-dimension of complexity, but only if, at the same time, I have access to the other dimensions, otherwise I isolate it.

I work a lot with young people in training, psychiatrists and psychotherapists, and I say, "Watch the language you use." During training when we discuss adult patients, even those with no particular psychopathological problems but only the stress of human existence, a colleague comes and says: "I have a lady in therapy whose husband... "and out pours a stream of contemptible things about her husband, and the colleague says, "The lady's husband is... "and makes a list and uses the verb 'to be'; then I say, "Excuse me, but have you met the husband?" she says "No, I've never seen him". "So why use the verb 'to be'? The only thing you are entitled to say is that the lady depicts her husband like this". In language, the husband becomes the ontologizing construct "is".

Therefore, working with teenagers without meetings and a non-episodic acquaintance with parents, the risk of such reification is inevitable. Three paradigmatic planes are in collusion: the relational conflict of the adolescent, his physiological epistemological radicalisation, the therapists' prejudices about parenting. You can easily imagine the consequence of this on the effectiveness of therapy.

I remember a colleague saying "At one point, based also on the discussions we had had, I decided to meet the mother of this 16-year-old boy who had quite a challenging psychopathology. I was worried and a little intimidated. The boy had been very convincing and I imagined I was to face a terrible woman who might attack and insult me. I was shocked to meet an unassuming, apologetic lady, who was instantly collaborative and grateful. She corresponded not at all to the description I was given!"

FV: It's the colleague's surprise that is surprising, right?

CP: You understand the power of reification so not knowing exposes you to these risks.

It is not "We always have to be all together", but let's get to know each other - the fact is this is your son, and you are the narrators of this son, your history, and the story your son was born into, you are the connecting bridges.

Then we'll figure out how to shed light on the tangles that complicate the story, we'll figure them out together, we'll find solutions, not aetiologies.

FV: It seems you are pointing out need for a broader declination of the clinical perspective, the capacity to navigate in different directions.

CP: In education, one has to train the minds of those who are advancing towards becoming professionals, to settle on complexity and not on reassuring reductionism, because younger people are much more flexible; when you propose this 'method' it is more fascinating, more complex, and less reassuring than saying that sessions lasts 45 minutes, you see only the patient, there is no meeting with parents, or the meeting takes place all together.

The mind, meanwhile, starts to adjust to this complexity because, basically it is human discourse with humans. To be humane means that you recognise the components of a family group as people and not functions. This awareness must be our mind-set and must translate into procedure.

Generally speaking, this is how I make sense of the situation and define the organisation of therapeutic areas, to understand which direction to go in and how to proceed. I have one or two sessions with the couple, at least two or three sessions with the mother alone, and with the father alone, to build up the parts of the whole picture, to partially understand, because when you meet them alone you meet the person, whereas if you meet them together, you meet them as functions. I meet you as the father of, or the mother of, and I explore the parental function, the maternal function, but I know nothing about the person. I try to understand how they function as parents, but not who they are as individuals, or what sort of people they are, or what their life story is.

Therefore, in the first phase, individualising interviews can have an important heuristic force.

It is usually the mothers who come and when you say that you would also like to talk to the father, they say, "No, my husband doesn't believe in these things, he would never come." Or "We are separated, he doesn't care." Whatever reason the female gives, it is no use asking, "The father won't come".

The conversation comes to a halt there, then I say, "I'll call him." One of the advantages of requiring the informed consent of both parents is that both parents need to come.

I call the father, and say, Dear father of X, I need you to come in so that I can help your daughter. Not: You need my help. But: I need your help."

You know, when you skip the wife's/mother's mediation and go directly to the father, they always come! Therefore, involving them as people and not as functions is very powerful and you achieve this by creating a space that is not therapy but a let's get to know each other. You are Giovanni, you are not the father of (function). I need to get to know Giovanni, and Giovanni get to know me, just as two people relating to each other before I consider his 'function'.

So, the effort for me is to see all the actors in the field as people, not as functions, not as figures (the mother figure, the father figure, the parental function! Does the language resonate?).

When you read the clinical reports of colleagues, you always find the term 'figure', mother figure, father figure. The expert will tell me how the parental function was exercised, we create groups to increase our competence, but people are reduced to functions.

The younger ones among us require this demanding approach; first side-tracked, then set in motion, it becomes progressively clear to them that this initial, disorienting effort makes subsequent clinical work simpler, clearer and more effective. Managing, as a method, this initial complexity, allows one to decide how to formulate mobile therapeutic fields for sub-units of a complex configuration. Otherwise, as often happens in real clinical therapy, unexpected variables impose themselves, question us, and force us to complexify the field. If the therapist is not well attuned to the way of thinking and the relative management of complexity, he will become disoriented and frightened like the boy who goes down to the supermarket to buy mozzarella for the first time in his life.

FV: I am pleased to hear you say that because I have always maintained that people who are used to making an effort and to thinking on a more complex level, as indeed adolescents and children stimulate us to do, later, the simpler situations can be easier to deal with.

CP: That's because you know where to find the links, the sense codes, and the signification matrices which are, by definition, spatialised, not within the individual, but within the intergenerational family community. This lapidary statement is even truer for children, and difficult adolescents who are unable to tell their own story except in fragmented, chaotic episodes (which may lead to a dangerous misdiagnosis). If you get used to operating on this level, then work becomes more comprehensible, and easier moment by moment; it takes some effort to become attuned, but later, as you progress through therapy, you will find yourself in a favourable position as the numbers check out much more easily and there is no paranoia about the world beyond your therapeutic space.

FV: I feel that we have covered several issues - would you like to add anything to conclude?

CP: What I really want to put across, as I said before, is that thinking of parenting as fragile, is not the fragility of that particular parent, therefore, helping parents to be less permeable to the reactions of their children is a major task today, where we tend to have to deal very much with fragility, as well as psychopathology, drugs, and so on.

What has happened with COVID and lockdown? If we look at the semantics of language, it is the semantics of fragility: those who shut themselves in their homes, those who no longer want to go out, those who …" Goodness me! What a trauma it has been, it's robbed me of two years of my life". We transfer this sense of collusion with fragility to the fragility of parenting, whereas in fact, it is a fragility of the family due to this social dispersion.

Ultimately, it is difficult to know who a child is the son or daughter of, because at nine months the child already attends a nursery and enters another level of parenting. Transiting between various institutions poses a problem for parenting, not for the parents, but for the question: "Which parenting forms the mind of a child, a

pre-adolescent, and an adolescent in the development of self, today?" The point is that that kind of 'parenting' does not create a sense of belonging to that superordinate system that we call community. This reflection can help explain why groups of friends in pre-adolescence and adolescence with their oaths of seclusion and loyalty that we know well, have such power. The nature of these modalities can determine a progressive and evolving life path, or paralysis and marginalisation.

I would summarize what we have said like this:

The weakening of the safeguards that the social community once supplied to the family means that young people are undergoing a dystopic transition. The experience and security deriving from the cohesion of community and family that formed the mind, is realised in adolescence in the peer community. It becomes a new experience which has little or no continuity with the first. An *ex novo* that can be an evolution of destiny, or a pathological destiny of belonging but with a very strong identity of self. This structural hiatus between different kinds of community needs to be examined. At the moment it is simply a proposition that requires further research. I believe it is important. It may be precisely within this hiatus that the lives of so many adolescents and young adults slow down or grind to a halt.



Conflict of interests: the authors declare no potential conflict of interests.

Ethics approval and consent to participate: not required.

Received for publication: 15 May 2022.
Accepted for publication: 15 May 2022.


*Licensee PAGEPress, Italy*
*Ricerca Psicoanalitica 2022; XXXIII:666*
*doi:10.4081/rp.2022.666*