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Towards a socially inspired psychotherapy

*Luigi D'Elia**

Abstract. – This article aims to redefine and renew the practice and theory of clinical psychotherapy in relation to the conspicuous changes in the social and political scenarios of the last decades of our history. New ways of observing pathoplastic phenomena are suggested and the relationships between macro- and micro- phenomena of psychism are explored. Certain internal arrangements of the psychotherapist are reviewed in the light of a renewed synoptic and wide-angle view. The alienating impact of current and specific social determinants on people's daily lives is assessed and a clinical practice of resistance in defence of dignity, freedom and truth of the contemporary subject is suggested.

Key words: social psychotherapy; social determinants; socio-psychic field; synoptic and wide-angle view; localisation of disturbance; clinical practice of resistance.

Introduction

Introducing the idea of social psychotherapy at the present time in history when dark clouds are gathering over our heads, appears to be a much-needed and necessary initiative if we consider to what extent the many critical aspects of the current state of health of our civilisation have an immediate effect on the psychic world of each and every one of us[1].

Social psychotherapy, however, has so far only been spoken of in terms of extending the tools of psychotherapy to the most disadvantaged social con-

*Phsycologist. E-mail: luigidelia1964@gmail.com

[1] Now that the pandemic phase of COVID-19 is over, we are observing its long-term medical and psychological outcomes; we have been witnessing over the past year a war on our doorstep, with an atomic threat; we are anxiously expecting an irreversible climate crisis in the coming decades, already announced by droughts and meteorological changes; we are the principal cause of the sixth mass extinction which is underway on our planet (Pievani, 2021), and there is, above all, a deep-rooted and widespread feeling of the impossibility to change the socio-political system which governs us (Fisher, 2009), where no transformative dialectic appears to be possible, but only positions of withdrawal or 'desertion' (Berardi, 2023).

texts, in terms of accessibility, sustainability, gratuity or subsidiarity of actions, mainly through the private-social sector, for the benefit of those who are unable to bear the considerable costs of a psychotherapeutic intervention, which is not at that moment publicly unavailable. The adjective 'social' alongside psychotherapy has been used to indicate, until now, only a demographic extension of the scope of a health discipline (only formally included in the levels of care), and an ethical stance in the direction of reducing social inequalities. In this sense, 'social' is simply any form of psychotherapy which facilitates reaching out to economically disadvantaged social classes.

In this article I propose, instead, to connote and re-signify this use of 'social' as an adjective through an epistemological, methodological, and procedural revision, albeit partial, of certain cornerstones on which most psychotherapy to date has been founded and operationally constructed.

Social psychotherapy, a question of therapist awareness or training?

The first inescapable starting point for social psychotherapy is the individual practitioner's awareness of the social value of the psychotherapeutic profession. The concept of social value includes both the presence of a precise social mandate[2] and the presence of a precise social function[3], the articulation of which then takes the form of a legislative framework and a professional profile. Lastly, social value, mandate and function in turn imply, in some way and to some extent, the presence both of a social body which as a whole is the bearer, albeit implicitly, of a demand, and of a social pact, which, albeit weakened, is nevertheless present and latent, and calls for answers regarding the spread of unease.

This awareness certainly concerns all the so-called 'ethical' professions, *i.e.*, those which have a humanitarian foundation as well as a tradition of service and care for the person. Specifically, of all the ethical professions, psychotherapy has become even more central if one considers that individual psychic criticalities automatically speak of, as we shall see below, collective psychic criticalities, of the suffering, in other words, of the entire social body. But not only: despite their absolute demographic transversality, psychic criticalities are emerging to a greater extent in the most disadvan-

[2] The reference is to the numerous problems of malaise that make citizens turn to psychotherapy and that together call for the specialist intervention of the psychotherapist as the privileged interpreter of the psychic world and its laws.

[3] The realisation that the social needs associated with the demand for psychotherapy go far beyond the very idea of a hypothetical job description for the psychotherapist. The social function in this sense is the acquisition of the professional's awareness of the malaise in today's society as a whole and the public role he or she plays.

taged social strata, which in turn are those least reached by psychotherapy services. In other words, the need becomes apparent to think of this profession as truly egalitarian, accessible and public.

But appealing to the political conscience and awareness of the individual practitioner appears to be a utopian or at least abstract operation especially when one considers in detail, with a genealogical look, the essentially and predominantly private history of Italian psychology and psychotherapy[4]. Psychotherapy was conceived in those distant '70s and '80s as a luxury for the wealthy few, and whose efficacy was still to be understood and demonstrated. Law 56/89 in fact sanctioned, with a serious historical delay, on the one hand the birth of a socially indispensable profession, but on the other it defined it as a profession accessible only to the fortunate few, endowing it with a classist and inessential character. An unresolved contradiction, the consequences of which we are all still paying today if we consider the secondary, not to say derisory, role played by psychotherapy in the public sphere in Italy.

Born with little or no public vocation, the profession of psychotherapist was to be organised in Italy in the following decades essentially around this legislative mandate, at the exclusive service of a private market in which tens of thousands of specialists would appear with varying fortunes and very high levels of blackmail[5]. Among the many side effects of this bizarre conception of a profession that is only nominally public, we find little or no attention or relevance given, in the universities and subsequently especially in the post-university training, to the variables and social determinants in the development and maintenance of psychological suffering and distress and their possible use in clinical practice. This is a conspicuous training gap that is present even in those training courses that are most attentive to the social work of their students. Social work that so frequently characterises the very first working years of a trainee psychologist, but to which very little attention is devoted, conceiving it in fact as a transient, thankless and preparatory apprenticeship for private practice. Standard training explicitly aims from the outset at the construction of a private professional, where 'private' too often coincides with the idea of the actual *absence* of a political perspective.

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4 See in this regard the reconstruction carried out in D'Elia's text, 'La funzione sociale dello psicoterapeuta' (The Social Function of the Psychotherapist), in particular in the introduction (p. XV-XXVII). As is well known, the outcome of the preliminary agreements between politicians and the medical order, which led to the constitutive law 56/89, envisaged an essentially private profile of the profession from then on: private specialisation (the only case), private profession, essentially private clientele, who became the only patrons of the professionals. Nothing to disturb the overwhelming power of psychiatry in the public sphere.

5 See on the subject of blackmail: Complacency of the precarious young psychotherapist and unpredictable feedback effects, in Altrapsychology (D'Elia, 2006).

How then should one answer the question that provides the title to this first paragraph: is considering psychotherapy a profession that responds to a social demand and that is at the same time imbued with social values more a problem of the therapist's individual conscience, or is it instead a function of his theoretical and clinical training? It is indeed undoubtedly difficult to develop a political consciousness of the profession if standard training completely eludes this area in the course of a student's training. The fields of knowledge that are useful in this regard[6] are generally part of the unconventional and collateral paths of the individual therapists, very often originating from professional commitments in the social sphere.

Social psychotherapy, a matter of synoptic and wide-angle observational field: micro and macro variably mirroring each other

Each variation in traditional settings, as in theories of technique, in the history of psychotherapy has its root in the changes, even quite perceptible ones, in the field of observation, which in turn is indebted to the socio-historical transformations taking place from time to time.

Childhood, family and communication, groups and institutions, the transgenerational, bodily and neurological implications, *etc*., each of these observational fields, once introduced into the corpus of previously acquired theoretical and clinical devices, has entailed a revolution in the clinical gaze and in the therapists' awareness. In a word, the entire history of psychotherapies could be described as a constant disruption of acquired certainties and a constant reconfiguration of the observational field whose consequences have then decisively impacted on clinical theory and therapeutic practices. Disruption in turn resulting from the socio-anthropological changes that have taken place over the last one and a half centuries, affecting society as a whole and the human type that represents it. Thus, psychotherapy is feeling the crisis of modernity, the rise and development of industrial and post-industrial society, the rise and crisis of capitalist-bourgeois individualism, the discovery of the world of children, the short century with its authoritarianisms and the two world wars, the atomic threat and the cold war, the crisis of the family, the youth and feminist revolution, and the entry into post-

[6] Of course, those therapists who, in the course of their training, have acquired multifaceted views (philosophical, epistemological, sociological, anthropological) in their profession are more facilitated in moving towards an exquisitely social paradigm. I refer to all those formations which, in caring for the patient's subjectivity, are aware of the intrinsic relational, group and transgenerational, transindividual matrix-nature of such subjectivity. I refer to all those formations which have a social theory of psychic phenomena and have definitively acquired a supra-individual approach in their theories of the mind.

modern society, the acceleration of history in the last 30 years[7], the countless technological revolutions, the advent of financial capitalism and the most sociopathic neo-liberalism, the advent of the digital era, the world of big data and algorithms, with immediate effects on the semiosphere and psychosphere, and lastly, the advent of artificial intelligence and its – still – embryonic impact on the lives of the next generations.

If we try, therefore, to think about what is changing before our eyes most rapidly and with the most concrete consequences on the contemporary human type, we cannot fail to realise that the scenario in which the most dramatic changes occur, is definitely the social field, its technosphere and consequently its psychosphere[8].

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[7] See on the subject of the speed of history the works by Paul Virilio (2004) and the concept of 'dromology'.

[8] Here is a rough bullet-list of the 'firsts' we are witnessing today as unprecedented precedents in history in recent decades:

- Life expectancy over 90-100 years
- Worldwide population explosion close to 8 billion
- Global hyper-connectedness
- Women's emancipation
- Anthropocene and risk of extinction
- Certainty of worsening life expectancy for coming generations due to the looming climate crisis
- Universalism and the unchallenged dominance of the capitalist system
- Knowledge of the human genome
- 58% reduction (in the West) in male fertility in the last 30 years
- Epidemic spread of depression
- World of big data
- Robotic and AI technologies and their impact on the world of work
- Technological speed *versus* slow ethical thinking.

And here are the consequent main mutagenic conditions found on the contemporary human type:

- Urgency of a new man-ecosystem pact
- Pervasive digital world and therefore more virtual, anonymous, incorporeal, imaginative, emotional
- Inflationary relationship with the infosphere
- Decline of the old communities and emergence of new evanescent or conversely sectarian communities
- The increasingly unbalanced and unfair rules of the world of work
- Competition *versus* cooperation
- Changing time management
- Mass loneliness
- Unnatural sleep deprivation
- Drastic reduction in sexuality (and male fertility)
- Changed relationship with the increasingly performative body
- Changed relationship with objects, increasingly bulimic
- Revolution of life cycles (dilated and overlapping)
- Endemic/structural crisis of the couple and the family (search for new forms of bonding) (lists included in D'Elia, 2020, pp. 29-37).

All of today's psychotherapies have their cultural and historical roots in the last century and therefore have in mind an essentially twentieth-century, modern human type, the bearer of criticalities entirely consistent with the historical period concomitant with it. If we wanted to describe the central theme of twentieth-century man in a title, we could say: 'The rise and crisis of the individual (and of individualism) and its conflicts with modernity'. A human type, in many ways, which has almost completely disappeared, whose anxieties belong to this recent past.

What is required, therefore, is for psychotherapy to be able to grasp the extremely rapid changes taking place in the contemporary human type, and learn to identify as soon as possible both the direction of the anthropological changes taking place, and the nature of the interactions between macro-social phenomena and intra-psychic phenomena, especially with regard to the most common forms of psychic pain that are widespread in our society.

What technologies and observational devices does the social psychotherapist therefore need in order to grasp this unprecedented complexity? Certainly, a new look capable of connecting numerous variables is required:

> '*Social psychotherapy therefore becomes the 'synoptic' professional act that manages to hold together, joined in a single gaze or, if you like, in a multifaceted gaze, ecological action and political action, together with the care of man and his affective, emotional, cognitive, relational problems. [...] Having overcome the world-mind dualism, the place of psychotherapy becomes the place, if we want it to be more or less conventional and artificial, or more or less formal or convivial, where two or more people meet to think about any mental place which is in some way meaningful.*' (D'Elia, 2020).

In order to grasp the new configurations of the contemporary human type, it is therefore necessary for the socially inspired psychotherapist to be able to 'widen his gaze in order to centre the target' (D'Elia, 2020), in other words, to use a wide-angle clinical gaze capable of synoptically grasping subjective pain and change in the socio-psychic field in its entirety and vastness. An unprecedented capacity for connection that knows how to unite the history of the patient-system (couple system, family system, group system) as a longitudinal, transgenerational temporal variable, as a stratified sequence of traumatic, de-evolutionary, unelaborated events, and contextually together with the anthropological changes in progress and their impact as iatrogenic determinants.

Historical time largely longitudinal and descriptive of the adaptive obstacles in the patient-system, and socio-anthropological space pervasively impacting and iatrogenic, must and can therefore be held together in the mind of a social psychotherapist.

Such a broadening of the gaze can certainly make use of tools already used by many therapists (*e.g.*, the genogram, to name but one, is an obser-

vational tool that can help in this sense), but in essence the innovative aspect of such a wide-angle gaze consists in trying to hold together a much broader articulation of life and problematic events of the patient-system whereby the whole of its inner life, irrespective of the theoretical model of observation and the way one wishes to describe it (inner dialogue, internal characters, internal group-formations, interpersonal constructs, beliefs, scripts, *etc*.), is already strongly informed by the social dynamic at work, which in itself is particularly pervasive and has never been so pervasive in the past.

In paragraph 1.5. of D'Elia (2020, pp. 37-48), we find an initial attempt at reading an observational field organised on different domains: macro and micro that are variably mirrored and affect our subjectivities with varying degrees of impetuosity. The construct isomorphism is used, but it is immediately specified that its use only makes sense when juxtaposed with the syntactic variability of the phenomena at play. Where the phenomenological syntax is strongly similar between the different domains, it is possible to read them as identical phenomena between micro and macro, between intrapsychic experience and social dynamics (the example of the strong isomorphism between the precarious and competitive society and the social withdrawal of young people is given in the book). Where, on the other hand, the syntax is different, we do find an isomorphism, but of much weaker intensity, in terms more of assonance than of true similarity (in the book the example is given of the rather tenuous relationship between the violence of song lyrics and consequential violent behaviour).

This is, of course, a first attempt to think in a necessarily flexible way of an observational grid that answers the question, so far unanswered, concerning the way in which historical and social macro phenomena are immediately mutagenic on the deeper psychic structures.

Social psychotherapy and overcoming individualism: the patient-system, its socio-psychic field and its localisations

In the course of the reworking of the professional field, the individual-patient is now to be understood as a pure abstraction. Probably also a useful abstraction related to a historical phase in which the emergence (I would rather call it the invention) of the individual in the ultra-liberal social model (Foucault, 1979) has led us, in spite of ourselves, towards a disidentified society emptied of metasocial and metapsychic guarantors (Kaës, 2010), deprived of intermediate and symbolic social structures, emptied of generative passages and functional community memberships, a society made up of individual-monads or, as otherwise stated, a society producing a mass loneliness held together solely by the impending gross domestic product (GDP).

If the patient-individual who is totally disembodied from his own social trajectories, eternally maladjusted and tirelessly resilient around his own planetary axis, is heading towards his inexorable twilight as an abstraction, at the same time, the patient-system and its articulated socio-psychic field appear in our therapeutic centres.

Approaching the socio-psychic field (or, in the words of Corrado Pontalti, the multipersonal fields (Pontalto, 1998), a construct synonymous with the socio-psychic field) of the patient-system requires a necessarily slow, longitudinal and always unsaturated diagnostic perspective. One is dealing with the system-patient (system-individual, system-couple, system-family, system-institution) as part of a whole, body-social, historicized and bearer of plots and networks that are still undecipherable, and therefore represent and encounter it in its specific environment in which the malaise has structured its own historical stratification, thus using information gathering and clinical interview techniques consistent with this approach.

An authentically social approach, therefore, does not set limits to its intervention and settings, internal or otherwise, in meeting individual and social problems in any abstract setting (one's own disciplinary territories) or concrete ones (the real places where problems emerge), wherever they might occur. For the therapist, knowing how to make connections between global criticalities and psychic criticalities becomes a source of new awareness capable of re-framing the difficulties with which he or she is confronted on a daily basis.

> '*The practice of an ordinary psychotherapist could be considered a particularly privileged laboratory/social observatory once we assume that there is a contextual implication and unveiling of the social demand for psychotherapy through the types of specific requests brought to psychotherapists, and the uneasiness often without a name does not belong only to that patient who is at the same time both bearer of a subjective uneasiness/discomfort, and location of a much wider and deeper uneasiness of which he is not an occasional spokesperson on behalf of a part of society.*' (D'Elia, 2020).

The very first and immediate consequence for the therapist's internal setting, following the acquisition of a synoptic and multi-articulated view, thanks to which the role of the interface between micro and macro domains comes to the fore, is the spontaneous depathologisation of many and most common symptoms and behaviours previously ascribed exclusively to individual vulnerabilities or defects or conflicts. In general, we speak of a decidedly depathologised view of human existence as a whole. If you like, a much more indulgent look or, to use a term from the religious tradition that seems perfectly fitting here, a much more merciful look at the specific travails of a highly confusing and accelerated historical era such as ours is today. Depathologising is by no means the same as downgrading or under-

estimating the impact of a specific suffering or psychopathology within a socio-psychic field, but means, as we shall see more clearly later, redrawing the framework of the multifactorial nature of causes with greater awareness and probably with greater adherence to the hypercomplexity of the phenomena at play.

If we take the example of the couple system, so clamorously under attack by socio-political variables and so endemically in crisis over the past 50 years, the model of the so-called traditional family (if such a model ever existed) having been completely consumed and fragmented, and the couple system having been isolated and increasingly exposed to its own destiny (increasingly inauspicious and increasingly transitory), here the need for a reinterpretation or reconfiguration of the most common dysfunctionalities no longer ascribable only to the shortcomings and dysfunctionalities of the individual members becomes even more visible, but rather it is necessary to rewrite and reread the whole so-called pathology of the couple through the new lenses of a history of the couple and the family undergoing full anthropological mutation[9].

This reinterpretation-reconfiguration regarding (de)pathologisation also appears to be necessary in many other cases, which here appear to us as glaring examples of the intimate interweaving of dominant socio-historical variables and subjective discomforts. It is the controversial diagnostic and nosographic attitude that holds the individual patient exclusively responsible for the unprecedented powerful cultural tendencies which correspond to the same anthropological and political mutations of human history in recent decades. I am referring in particular, but not only, to the categorisations concerning the entire narcissistic spectrum[10], all the so-called new addictions and behavioural addictions, all the so-called attention or hyperactivity disorders, all the new pathologies of avoidance or social withdrawal, all the sleep pathologies, and so on (here the list becomes very long indeed).

The reference is to pathoplastic organisers that use (through strong isomorphism) the same syntaxes as the social phenomena that structure them. The social world 'speaks' the exact same language on both the macro and micro levels using roughly the same rules, the same semiological horizon, the same codes of signification which organise the intrapsychic world.

I wish to make it clear, for the sake of accuracy, that the assumption of a new polyhedric outlook, as I suggest, establishes a strong relativisation or, if you like, the decline of the very idea of the individual according to the

9 See in this regard the work of Scabini and Cigoli (2000) and their focus on the social determinants on the lives of today's couples and families.

10 It is difficult to distinguish in a 'narcissistic society' (as C. Lasch indicated back in the '70s) which are really psychopathological drifts and which are socially accepted normopathic adhesions.

philosophical categories of modernity, but this rewriting has the effect of exalting and enhancing the function of human subjectivity in a key of interconnection rather than of pure and simple heroic self-determination. The decline of the individual (in the sense of modernity) does not coincide, as one might naively imagine, with the decline of subjectivity; quite the contrary, it means instead the enhancement of a more urgent collective subjectivity, more connected and more responsible for the common good.

In clinical terms this does not at all mean neglecting any aspects in the diagnostic observation and in the setting of therapeutic strategies, the specific vulnerabilities and the unique and unrepeatable characteristics of the individual person, his unique biography, his courage or hesitations and the related personal responsibilities, far from it. It means framing the vulnerable or dysfunctional part of the personal biography as a part of the whole, not necessarily as the most decisive in causing disturbing events. As is already the case in transgenerational studies with regard to the well-known ego-alien factors.

The socio-psychic field of the patient-system is therefore configured, as mentioned above, as a new framework of clinical framing whose variables of psychic space, extended to the socio-anthropological domain, and of time, largely longitudinal, extended to the transgenerational, observe the person (or the group formation) as the historical node in a plot, bearer of stratified and mostly unknown pain.

To enable us to further specify and investigate thoroughly the concepts expressed here, an insight from the group-analytic model comes to our rescue at this point: the concept of localisation.

Foulkes (1948) writes, anticipating by several years the insights of systemicists: 'If one considers a psychological disorder primarily in the relationship between people, *i.e.*, localised in the interaction between people, it follows that it can never be attributed to a single person. In a group-analytic situation disorders can be traced in their ramifications'.

Foulkes himself does not deny, in his later argumentation, that such a symptom is rooted in such an individual, but he immediately adds that it is nevertheless the group that must answer for it (Foulkes, 1948). Localisation, in short, means that the disorder is knitted into much broader relational plots (ramifications) in persons who are in fact mere spokesmen for it on behalf of all.

Resuming and relaunching this intuition at this historical moment in time means precisely describing a specific topicality of the psyche-world relationship with specific and in part unprecedented characteristics. Again Foulkes, still arguing about the concept of localisation, commented 'let us not think too lightly of the pathogenetic power of life today!' (Foulkes, 1948). Seventy-five years after these considerations, not only do we find this impact of the pathogenetic power of today's lifestyles as exponentially

higher due to the spread and development of communication and surveillance technologies, but we are also faced with a peculiar pervasiveness of the individual-system relationship never encountered before in other historical ages, so that the individual's mechanisms of introjection of systemic source codes appear particularly, and complacently, adherent, accomplished and refined.

Hence, a concept born and developed as one of the many corollaries of group-analytic epistemology, such as that of the localisation of disturbance, can now easily and correctly be extended, in the light of these introjective and at the same time pervasive mechanisms described above, to the clinical vision of a social psychotherapy increasingly aware of the new laws relating to the contemporary human type.

Social psychotherapy: the world breaking into the therapy room. Resistance *vs.* resilience

In the flow of reflections appearing in this essay, there is a close coherence between all the conceptual steps that are proposed:

1. need for a new training perspective that is inclusive of mutagenic social variables and acquisition of political awareness of the profession;
2. acquisition of a new observational field, synoptic, wide-angle, longitudinal, capable of making new connections between observational domains according to variable isomorphisms;
3. focus on the socio-psychic field of the patient-system, overcoming individualism and relaunching the localisation construct and consequent revision and depathologisation of the most common psychological disorders;
4. clinical focus on the need for 'resistant' rather than merely 'resilient' work, as we shall see in this and the next section.

In this section, we try to consider some of the consequences of this approach and in particular try to examine how our clientele is changing with respect to the needs that are most often expressed in our clinical practices.

I therefore start with Marco Rovelli's very recent essay, 'Soffro dunque siamo. Il disagio psichico nella società degli individui' (Rovelli, 2023), where we find a very accurate survey of the state of the art of current psychic pain in Italy. From the epilogue of that essay, we draw this important quote:

> '*The culture that overexalts individualism, that exalts the privateness of experience, has also found allies among psychotherapists: the model of psychotherapy is a private practice where you and the patient are there; it is a model where social determinants disappear, not so much at the aetiological level, since everyone more or less recognises them as elements of mental illness, but in including them as an integral part of the treatment: work, home, money.... We*

> *need to introduce the study of social determinants not only into the aetiological model, but also into intervention strategies. The evolution and outcome of mental illnesses depend not only on clinical variables, but in an equally decisive way, on variables related to the strategies and organisation of health services.*' I would add: public and private. (Rovelli, 2023)

If these are the converging conclusions of such a scrupulous and careful independent researcher, one wonders why the dominant mainstream belonging to the overwhelming majority of psychotherapies, scotomises the discomfort inherent in our most common lifestyles and lingers in rearguard reductionisms so blatantly refuted by the evidence of social transformations. It would indeed seem that accessing a more complex thinking that implies the undeniable iatrogenicity of social determinants deeply embarrasses our internal framework, which is increasingly dogmatically positioned on its own reductionist scotoma[11].

We refer not only to the rapid aging of traditional concepts of setting in the various operational models, especially with regard to the emphasis on duality, but to the worn-out external world/internal world conceptual polarisation on which the majority of our paradigms have thrived and acted.

What is in fact the cultural implicit that an ordinary patient can expect when crossing, often with effort, doubt and confusion, the threshold of a psychotherapeutic practice or institution? Which prevailing mainstream does he or she approach?

This implicit (but often it is instead clear explicit) requires the patient first of all to relinquish the childish idea of attributing the causes of his or her anxieties to the world that is falling apart, to precarious work that creates anxiety, to relationships at work that are increasingly contaminated, to affective, family and social relationships that are less and less reassuring and, on the contrary, sources of anxiety, to the feeling of loneliness and maladjustment that haunts us. The patient needs to understand as soon as possible that the only, partial, system on which it is possible to act is himself, the individual, his own planetary axis which moves and creates the illusion that it is the sun and the moon that set and rise. Attempting to change the world is a futile and harmful operation because the world is unchangeable.

The implicit mainstream message to our patient easily becomes a metacommunication about his lack of resilience in reprogramming his original

[11] Only complex thinking is able to connect and consequently identify the key needs that link the fate of the world's global (not just mental) health. See this enlightening and recent summary published in the Lancet regarding the global health priorities of the near future. Namely: climate crisis, child health, advancement of research, mental health, universal access to care. As can be seen from this summary, we are now talking about health and at the same time holding together social and environmental issues as central and decisive for the future of all health.

maladaptive patterns (unconscious, cognitive, emotional, relational, bodily), within which it is ultimately possible to trace the causes of his own malaise.

> '*Dear patient, in essence, no one denies that the world out there disgusts us and that perhaps many of the causes of your discomfort depend on it, but do the reality check: after all, the world has always been disgusting and a source of discomfort, so what's new? And trying to change the context of life is a futile and childish attempt. Instead, look inside yourself and try to know and correct yourself, if you can. Resilience! NOT resistance!*'

Thus, states all too often the mainstream of today's psychotherapy.

The patient who can really benefit from the relational technologies of today's psychotherapies is someone who, in essence, assumes this intrapsychic and resilient perspective as soon as possible and becomes the protagonist of a treatment at the centre of which is himself exclusively, his own planetary axis, his own wounded individualism. The good patient uncritically espouses the individualistic mantra on which the same cultural assumptions are based that are sometimes at the origin of his malaise. If you like, it is an explicitly guilt-ridden or self-culpable mantra. It is the patient himself who is then able to endure the interminable and, for him, incomprehensible 'analytical' silences, or worse, to willingly endure the homework to reprogramme his own biases, or worse, to silently accept the idea of the usefulness of 10-15 years of therapy. He has surrendered himself, often involuntarily, to a therapeutic system that asks him to obscure the world and its follies, and all he is left with is to dig endlessly within himself and discover his own defectiveness.

For a countless number of reasons, fortunately, the 'demography' of a psychotherapist's practice is gradually changing shape: twenty or thirty years ago the patient's appeal to resilience mentioned above still had a reason to exist and an intimate, homeopathic, efficacy of its own thanks to cultural contiguity, but today the percentage of patients for whom this 'order of discourse' continues to make sense has been drastically reduced and a second percentage of patients for whom social determinants appear decidedly prevalent and for whom resilient discourse has become increasingly unacceptable and borderline sarcastic, has overcome it[12].

A growing percentage of patients for whom it has become necessary to identify real paths of liberation, of regaining lost dignity, of overcoming anhedonia, of emotional literacy, of subjectivisation, in a word the opposite

[12] On the contrary, there is an increasing number today of 'migratory' patients, more than before, who often change therapists in search of greater closeness to their condition of suffering and who experience our most common clinical settings as completely incomprehensible and inhospitable.

and contrary slogan to the one expressed here: Resistance! NOT resilience!

If resilience becomes an ideologised practice and an implicit dogma of psychotherapeutic practices, it automatically becomes the intimate enemy of resistance, where the latter turns out to be the only, inescapable, solution to protect dignity, truth, liberation of our patients, as a preliminary act for the defence of their psychological health.

How, then, should we assess the irruption of social determinants into the sometimes muffled and artificial atmosphere of a (private or public) psychotherapy practice. And what does this irruption imply about therapeutic strategies and how does it change the internal/external scenario of a session if a radically wide-angle modality such as the one suggested here is applied?

First and foremost, it is necessary, as mentioned above, to introduce a historical and psycho-political viewpoint, which reviews every totally unprecedented aspect of this historical phase and assesses its mutagenic effects on an anthropological level, as well as its mutagenic repercussions on the most common lifestyles, the current human type and its most common perspectives. A social psychotherapist who takes the role of social determinants seriously assumes a definite ethical-political responsibility with regard to social bonds and the social body as a whole. Responsibility regarding the political weight of his professional acts in relation to the systems and subsystems he encounters.

To widen one's gaze in order to hit the target is like saying that a social psychotherapist 'crosses variables' on hyper-complex planes of encounter and does not scotomise reality in order to make clinical case histories, mostly new in form and substance, fit into worn-out school nosographies in the name of evocative inertia. Knowing how to recognise, clinically, a phenomenon that is even relatively new in form or substance instead of continuing to read it with the same old lenses necessarily implies a social perspective.

On a purely methodological level, the non-ideological position, in the perspective of social psychotherapy, does not aim to discard (at least not entirely) any procedure, albeit scotomic, preceding and common to most models of intervention, but retains in its technical memory every acquisition of the psychotherapeutic scientific background useful to the individual patient and his unique and unrepeatable condition.

However, a more complex thinking is introduced in which the variables involved contemplate the entire existential and social spectrum of the patient-system (or couple-system, or family-system, or group-system) which at that moment localises a certain problem or malaise that can no longer be attributed or restricted only to disevolutionary, dysfunctional, genetic, intrapsychic, individual or family factors, but becomes the embodied testimony of the pain of the entire social spectrum of which that patient-system is, not by chance, the painful spokesperson.

The postmodern human type appearing in our studies, although partly changed and mutating, still closely resembles the previous human type, the modern one, if only because of the unprecedented speed that today renders a previous era, obsolescent in the space of only 1-2 generations, does not allow any sapiens to reconfigure their mental and bodily maps to the needs and demands of this contemporaneity.

As a result, many of the inconveniences (especially in the relational sphere) look very much like what would happen on a computer on which two pieces of software, with the same purposes and similar scripts but different ages, are loaded: one old, the other recent, which fatally conflict, bogging down the operating system on the same procedures. The old software plays with old languages and codes, the new one introduces entirely new variables and requirements. Result: computer crash! The result, in turn, is the introduction of grotesquely paradoxical positions such as 'Love is eternal as long as it lasts' (title of a well-known Verdone film), *i.e.*, the now structurally transitory condition of today's couple projects (but this is only one example out of a thousand possible), which is increasingly frightening and for many still dense with a feeling of eternity that has in fact vanished in the most common experiences. Medleys, anachronisms, paradoxes, typical of these historical phases of transition, immediately become clinical uncertainties and before that, diagnostic uncertainties with which one learns to live and interact.

The close temporal proximity and the extreme rapidity with which the new pathoplastic or simply psychoplastic phenomena present themselves (think, for example, of the recent phenomenologies of social withdrawal, desertion from the dominant paradigm of the performance society, the drastic reduction of pleasure and desire or even the new widespread sexual fluidity in the very new generations), allows us to describe as direct witnesses and from the inside each temporally contiguous socio-psychic movement in a comparative manner, describing its cultural transitions without necessarily enrolling these mutations in a psychopathological framework.

Paradoxical phenomena, typical of transitional ages, such as the presence of blatant cultural atavisms in tendencies, even collective tendencies, of extreme pre-modernism, are, in larval or emerging forms, rather common conditions in today's patients[13].

Or young women and men who, for example, fear any intimate contact

[13] In this sense, the recent mass phenomena linked to the pandemic and the related counter-phobic and denialist responses of the no-vax archipelago are a striking example of how some more explicit and obvious social determinants immediately impact personal vulnerabilities, sometimes leading to frankly psychopathological responses, transient or otherwise. Consider the mass phenomenon represented by an apocalyptic, supremacist psycho-sect like Qanon in the United States.

and any relationship as an unprocessable source of disruption. Generative anxieties already present in adolescents and young women and men, terrified of the future and of any foundational commitment. Urges towards totalitarian and sectarian community memberships in search of certainties lost forever; more or less voluntary confinement towards forms of dependency and nesting in the family[14] as well as work contexts (workaholics); new and ever-changing forms of substance and behavioural addiction. Habits of life considered ordinary but which have become sources of extreme stress: circadian stress, prolonged insomnia, drug abuse, undercurrent (languish) and/or clinically relevant depressions, anhedonia, alexithymia, eating disorders, larvae or extreme forms of burn-out in most work contexts; increasingly extreme family conflicts; social withdrawals; school drop-outs; new forms of youth sociopathy, etc.

Social psychotherapy as a clinical practice of resistance: subjectivisation *vs.* subjugation: dignity, liberation, truth of the subject

How does the clinical practice change in the face of the multitude of variables that our wide-angle gaze is suddenly interwoven with?

First and foremost, we are moved towards the patient-system by a new, greater, solidary, human closeness, a new participation in the same present effort of living, a shared feeling of a world that almost always upsets and disgusts us, to which we are unable to belong and adapt. A hyperdromic, inflationary world, whose infosphere is dense, confusing and noisy, a world that continually unsettles us in every existential aspect, that requires extreme sacrifices from us, that treats us as infinitely flexible and elastic, we who are not so flexible and elastic, structurally, biologically. A world that pulls the rope to the point of wishing, with total sociopathic indifference, to break it, that asks our young people to work for free, that steals their future, that tells us there is no alternative to this looming, dark present, that steals our attention with its digital devices, that wastes our time in totally useless and harmful activities, where we appear eternally bent over our smartphones even as we cross the street, that allows us to sleep only half as much as we need to, that saturates us with rubbish, both concrete and psychic, of every kind, that isolates us more and more, that fills us with thousands of images, reels, memes, words that we will forget ten seconds later, that stuffs us with psychotropic drugs, that frees up at every turn any offence to human

[14] One thinks of the biblical dimensions in Italy of the NEET phenomenon, and of the Hikikomori subgroup where we are numerically second only to Japan. In this regard, see Pontalti's (1999) seminal attempt to redefine in an anthropological framework the dependent disorder as a context disorder (symbolic or concrete).

dignity in the name of the market god[15]. And again: a world where injustice and social inequality become ever more unavoidable, where the gap between the very few who are ever richer and the very many who are ever poorer grows ever wider.

The clinic of resistance appears and is justified, in a dialectic with the previous clinic of resilience, in function of new scenarios of today's reality which I tried to summarise in Table 1 (Stanghellini & Muscelli, 2012; Han, 2012; 2015; Crary, 2019; Godani 2019; Loach, 2019; Mazzocco, 2019; Zoia, 2022).

The scenarios on which forms of psychological suffering rest and insist are changing, and at the same time new forms of discomfort are emerging, direct emanations of these scenarios. The psycho- and patho-plastic speed increases dramatically, and more and more explicitly and directly the forms of suffering speak a language that is increasingly recognisable and adherent to our way of being in the world in the present decade.

1) The clinic of resistance is characterised first and foremost as an awareness of inhabiting a world, in its main organising codes of the social and the psyche, which is distinctly: i) more accelerated; ii) more pervasive; iii) more introjective (of the psychic and economic organisers of society); iv) more passivising; v) more anxiogenic and despairing compared to the world immediately before (we are talking about a few decades ago).
   This disorienting feeling is in itself a reason for the therapist's greater emotional closeness to the patient-system, who is also disoriented and bewildered like everyone else.

> '*Learning to read certain relational phenomena as entirely structural and isomorphic to the prevailing social codes is not a simple interpretative operation, but serves to understand the margins of movement and reaction with respect to that situation. Since it is not a single psychopathological drift attributable to the individual, but a systemic precipitate relating to precise organisational and institutional cultures, it totally changes the internal representation of the trauma (of the patient), even if the related emotions remain the same.*' (D'Elia, 2020)

[15] In essence, a world that has long since crossed the threshold of tolerance of our species' bodily and cognitive capacities of endurance, a sacred threshold. Therefore, a blasphemous world, we could say in a nutshell. Where by blasphemous, a term borrowed from the religious lexicon, we actually mean that desecrating act, to blaspheme, which signals the trampling of sacred territory or a sacred function. The perimeter of the sacred in this context is the one defined by the psycho-neuro-somatic uncrossable limits endowed to our species. Psychic and physiological functions that cannot be infinitely malleable: from eating, to sleeping, to living with one's neighbour, to paying attention to a congruent number of stimuli, to pursuing or, conversely, renouncing one's aptitudes. Blasphemy is to have imagined as flexible limits that are not in the name of lifestyles that are complacent with the demands of the economic system (see bibliography Sennett, 1998).

Table 1. Clinic of resistance's new scenarios.

Scenarios of the technosphere	- Life on the web (virtualisation, hyper-connectedness, emotionalisation and decorporealisation of experience, pervasiveness of attention marketing) - Big data (automation of social control processes through algorithms, revision of the very idea of freedom. [Han, 2015]) - Artificial intelligence (robotization, still not entirely predictable impact on common habits and the world of work)
Scenarios socio-political-work	- Existential precarisation and progressive acquisition of the extemporaneous 'rider' model (instantaneousness, Stanghellini, Muscelli, 2012), Loach K. (2019), Sorry, we missed you - Mobbing and burnout, no longer as mere pathologies of organisational systems, but as their codified patterns - Drastic rejection of work and labourism in recent generations (end of work as an element of civilisation and self-fulfilment) - Progressive impoverishment of the middle class and widening of inequalities - Drastic reduction of welfare and rights: education, health, welfare, housing - Breakdown of the social pact, end of the social elevator - Progressive distrust of the political classes and disconnection from public needs
Scenarios socio-relational	- Individualistic and disaggregative drives - Proliferation of pathological communities - Competition *versus* cooperation - Performative drives and adherence to performative models - Endemic crisis of couple and family, search for new organising codes of the family, increase in the fluidity of sexuality - Denatality and generative anxieties - Reduction of pleasure and sexuality (Han, 2012; Godani 2019; Zoia, 2022) - Reduction of relational commitment and reciprocity behaviour - Massive commodification of existence and relationships
Scenarios of the psychosphere	- Reduction of time for self and others (Mazzocco 2019) - Pervasive assertion of attention marketing - Drastic reduction of sleep and proliferation of sleep disorders (Crary, J., 2019) - Chronic fatigue and epidemic spread of subtrack depressive experiences (languish) - Increased stress - Fatigue in planning for the future and the present - Social withdrawal in the younger generations - Increase in dependent behaviour - Increased feelings of emptiness and despair - Increased anxiety and depression and suicidal behaviour

And further on:

> *'The social competence of a therapist, not generic and not unspecific, but punctual and informed, is certainly an element in the implementation of therapeutic efficacy as it favours changes in the internal representation of trauma and accelerates its psychic metabolism as well as fostering greater empathic closeness between therapist and patient. A therapist who, conversely, is easily surprised or disoriented by new social phenomena, who does not possess adequate hermeneutic keys and remains anchored to anachronistic theoretical interpretative inertia or reductionism, will fatally turn out to be more distant and less in touch with the patient's problem.'* (D'Elia, 2020).

2) Secondly, the resistance clinic has acquired in its expertise a greater articulation of observational variables (the aforementioned synoptic and wide-angle view) and invariably applies it to every clinical situation. Knowing how to hold together personological aspects and family scripts, specific contextual aspects, historical-cultural aspects and historical-cultural aspects and potentially resilient collateral and intervening aspects, of each patient-system means:

> '*Taking into very high consideration not only the past history and evolutionary, even transgenerational, stumbling blocks, but to consider the patient's entire history (his or her entire psychobiography) as significant in the same way as his or her childhood, attachment styles, etc.'. Therefore, it becomes essential to evaluate every possible, single,* ***borderline crisis****, whether remote or recent, which in the patient's history has represented a problem, a block, a failure, a disruptive element, an indigestible discontinuity, an evident or undercurrent traumatic element. The intersection that needs to be observed is therefore to be understood between vulnerable aspects on a personal, family, socio-cultural, contextual and contingent level. [...] The interweaving of the personal-historical variables, of the family-historical variables, meets, without any theoretical friction, with the interweaving of the socio-cultural history of the individual, of his family, of the groupings, of the anthropological variables on which he insists. Any conflict or trauma or personal difficulty or vulnerability of a patient thus becomes the intersection point of all the variables at play: biological variables, emotional, affective, cognitive, personological, environmental, socio-cultural, anthropological, contingent and collateral resilient or anti-resilient factors, etc. One can and must, therefore, keep together all the existential planes: individual, family and social planes, which become a map on which one can move for the identification of truly transformative psychic operators, being able to reconstruct some of the complex passages of the therapeutic pathway and the significant stages that have represented the successful evolutionary junctions [...] The possibility of holding together on this map, which I call the socio-psychic field, all the planes, all the codes and all the languages of this observational articulation, being able to compare, distinguish and/or associate them, radically reorganises the clinical priorities and orders them according to a sequence that corresponds to the priorities of the patient-system.*' (D'Elia, 2020).

And further on:

> '*The story that the patient-system tells us involves and implies many other stories and events variously intertwined and overlapping on the different planes of individual biography, of the much more longitudinal family biography, of the historical cultural climate with its own specificities. Of all this we can only observe the last piece and only the last narrative voice, that of the patient who is only able to tell us a problematic fragment of his life, the one that leads him to us. [...] If we are lucky and above all trained to specifically listen to this intersection of narrative lines on different planes (imagine the most daring fugal counterpoint by Bach to get a rough idea of what I am trying to describe), we can perhaps guess at the hundred other stories unfolding in transparency, and glimpse the watermark with the complex web of narrative lines underlying the main one. [...] This is the hermeneutic exercise of a psychotherapist trained to widen his gaze and turn on the wide-angle lens of his lens. Every story, personal and transgenerational, has its own specific stumbling blocks, written in transparency on photographic plates that are by no means sharp. Many stories resemble each other in some historical invariants, others differ in their traumatic specificity. Knowing how to read the histories of families, of children's upbringing, of problematic junctions, of specific difficulties within precise historical-cultural frames, within recognisable flows, means being able to refer to coordinates common to those of the patient. Perhaps even trying to speak the same language as his.*' (D'Elia, 2020).

3) Thirdly, the clinic of resistance is a clinic eminently of subjectivisation of the contemporary human type. In other words, it tends to read certain contemporary phenomena as intrinsically denying the dignity, freedom and truth of persons, conditions that precede any discourse on psychological health. In this sense, a social psychotherapist is anything but neutral (politically) with respect to what is in the psychological and social health interests of the individual citizen and his or her communities. Remaining neutral with respect to the increasingly obvious and intense opposition between the interest and development of social systems and the interest and health of individuals and communities, which is becoming increasingly polarised in our most recent political and economic scenarios, in fact means not taking a stand for and alongside the well-being of citizens (D'Elia, 2015).

An ambiguous and contradictory position that would automatically place a psychotherapist, at best, in the non-existent and unlikely position of mediator, or, at worst, in the position that we can define here as the 'homeopath of the present', in fact colluding with the iatrogenicity of the current social reality. Indeed, no mediation is possible between the interests of our GDP and the psychological health of sapiens. This realisation is very clear to all those who are fully familiar with the iatrogenic phenomenologies of the current human civilisation and its conspicuous consequences on the entire ecosystem.

Moreover, the introjective phenomena of complacency and unconscious complicity that characterise the current automatisms of participation in the daily lives of each one of us, and which in fact allow the survival and expansive continuity of the current inflationary economic mechanisms, are well known. We can consider as paradigmatic all the free and spontaneous activi-

ties that the vast majority of us carry out by simply participating in life on the web, and which generate direct or indirect earnings for the largest multinationals traceable to such activities in terms of big data information expendable in terms of control and power on the markets. We actually work for free for Google, Meta (Facebook, Instagram, YouTube), Tiktok, *etc*., in exchange for a promised collective progress that ultimately results in an increasingly unequal world[16]. The complacent pattern is the one Freud identified in his essay on the Malaise of Civilisation (1929), 'Civilised man has bartered part of his chance of happiness for a bit of security', with the difference that today it is no longer just happiness and security at stake, but dignity, freedom and truth in exchange for an increasingly less sustainable life that has become a commodity whose Sell-by date has expired.

The root and matrix of this unjust exchange can be found in the recent past in the consumerist foundation of the modern subject. The consumerist paradigm on which the modern human type was conceived and constructed after the Second World War (Foucault, 1979) and on which neo-liberalism has in turn constructed the feeling of truthfulness of reality (Foucault, 1979) in conjunction with the economic foundations of society, is the same paradigm that envisages the active participation of the contemporary subject (entrepreneur of oneself) in the construction of one's own happiness through participation in the implicit rules of the economy and its invisible (albeit salvific in the collective imagination) codes.

The subject, first modern and then especially post-modern, hypercoded in the economic system, is in fact usurped piece by piece (and with his own active, collusive, involuntary participation), of any real possibility of choice.

Thus, today we have reached, in the most delusional version of socio-political development, a condition in which it is no longer negotiable that:

- politics takes charge of the rules of the economy (now firmly in the hands of a very few monopolist oligarchs beyond all control);
- politics consequently takes charge of welfare and reduces any inequality and any difference in opportunities between peoples, and between persons and social sectors of the same people;
- politics is willing or able to take care of people's basic needs;
- people can imagine introducing lifestyles that are truly alternative to those of the prevailing mainstream or can live more frugal and not un-satisfied lifestyles without maximum discomfort;
- people can actually avoid, with feelings of discomfort, the surveillance of their daily lives (Zubof, 2019).

[16] The promise of a universal development of technological progress and its egalitarian effects on the lives of all the world's citizens is the same promise that characterised capitalism at its origins, and is still repeated today, in its infinite narrative variants, in every involutionary step of modern financial capitalism and the globalised new economy. The impact on collective credulity remains unchanged and the hope that a collective intelligence or genuinely democratic technology will one day save us is repeated today, once again, as a tragic and naive omen.

This configuration of the stable relationship between the ordering rules of the economy and the ordering rules of the subject's psychic world, in their continuous mirroring and mutual reinforcement, is in fact called alienation, or to put it in a term closer to us and which recalls the same root 'subject', it is called subjugation, that which deprives the contemporary subject of his truth, his freedom, and his human dignity, reducing him first to a consumer (and no longer a citizen), in the illusionary idea of thereby constructing his own happiness, then finally to a torturer of himself (Han, 2015), in surrendering himself totally to a world that demands of him total, spontaneous self-sacrifice.

Arriving in our surgeries, bearing the burden of his own psychological suffering and at the same time with a very serious deficit of dignity, freedom and truth, hence of psychological health, the contemporary subjugated subject appears to be greatly thirsty (and therefore in debt) for subjectivity. Beyond (or before) his specific psychological problems, this subject very often presents himself besieged by all kinds of stress, by an underlying existential malaise that is incomprehensible to him, made up of chronic fatigue, anhedonia, allexithymia, insomnia, lack of time and energy, all kinds of family and work problems, often with unresolvable economic distress, stuck and sunk in a lifestyle that is too elevated where he can no longer secure either himself or anyone else, or vice versa crushed in a lifestyle that is too low, with no way out and that he can no longer tolerate.

If young and belonging to the latest generations, this general picture of the contemporary subject is generally even worse as it is characterised by a greater awareness of the absence of margins and movement, a voiceless resignation to impotence and an awareness of the absence of possible, colourful and positive futures.

The clinical practice of resistance was thus born in this precise historical and anthropological context and pursues the attempt of an alliance with the patient-system in view of its re-subjectivisation and its hoped-for liberation.

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