EFPP JOURNAL

CROSSING BOUNDARIES

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The second issue of our EFPP e-journal is on the theme of "Crossing Boundaries". The appeal of this subject has imposed itself to us by its possible meanings varying from freeing or getting rid of limitations to transgression. As with all issues of the e-journal, the proposed theme is open for authors to interpret according to their own reflections.

The vision of the EFPP e-journal is to work across boundaries in collaboration with the EFPP membership, authors and readers, learning from their different countries, different languages, and different cultures including psychoanalytic cultures fostering pluralistic discussions.

In this issue, we present papers from four different sections of the journal.

In the *Clinical Section*, Ekaterina Koshkina's paper addresses the topic of adolescence by presenting a rich clinical case that studies the internal world of an adolescent haunted by a painful sense of belonging nowhere; their experience being in "a territory that has no borders".

Fiorella Monti and Barbara Giorgi's contribution puts forward a parallel between infant observation and psychotherapy practice exploring their differences and similarities.

In the *Study Day Section*, Verity Emanuel's paper offers a very compelling and illustrative case presentation in which she addresses the challenges of the child psychotherapy model working in parallel with the child's internal representations of self and others and the parents' representations of their child. The discussions of the paper by Cristina Călărășanu and Gabriela Kuell open new perspectives on the clinical case and creative lines of inquiry derived from them.

The *Institutional Section* includes detailed information regarding regulations of psychotherapy in different countries. A brief presentation of the EFPP regulation working group is followed by the regulations of psychotherapy in France, Netherlands and Portugal.

Finally, in the *Book Section*, Gianfranco Buonfiglio introduces four books on the national conferences of The Italian National Network of EFPP (SIEFPP).

Clinical Section

Adolescent Crisis of Integration

Belonging Nowhere: The Integration Crisis of the Adolescent Girl in the Psychotherapeutic Process

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There is no pain, you are receding
A distant ship's smoke on the horizon
You are only coming through in waves
Your lips move, but I can't hear what you're saying
When I was a child, I had a fever
My hands felt just like two balloons
Now I've got that feeling once again
I can't explain, you would not understand
This is not how I am
I have become comfortably numb

Pink Floyd, "*Comfortably numb*"

Adolescence is a fragile period where the individual navigates the anxieties of object loss, seeks new frameworks of belonging, and works towards the integration of a cohesive, autonomous identity.

When this journey of internal migration is encumbered by fragmented and shifting realities of the external world, we encounter in therapy a young person who inhabits a state of profound emptiness, loneliness, and a painful sense of belonging nowhere. The internal world becomes *terra nullius* — an unclaimed, deserted psychic landscape, devoid of secure objects or anchoring relationships. It implies the absence of sovereignty, there is no internal order, only fragmentation of isolated territories. It becomes extremely difficult to survive and develop without a sense of belonging and recognized borders. In such a territory, the parental couple does not serve as a stable source of authority and support that could provide guidance, protection, and a sense of belonging.

In a state of *terra nullius*, identification becomes complicated: there is no one to belong to, to identify with. Migration from *terra nullius* is difficult**,** as it requires a departure from a named, claimed territory. Without a place of origin — a land to leave behind — the very act of migrating collapses into endless drifting without direction or destination. There is no starting point to map out the route. Inner *terra nullius* leaves the adolescent unable to either hold on to objects or to grieve their loss.

The therapeutic journey becomes obstructed, as the individual's capacity to imagine a shared experience — to exist alongside another within a holding relationship — has never been sufficiently established. Without a stable, internalized object to lose, there can be no mourning, only endless drifting through absence and emptiness. In such a state of inner homelessness, the future remains an unmarked, uncertain territory — impossible to enter, impossible to claim.

An adolescent faces a difficult task — to take a step from the past into an unknown future. This is a challenging transitional stage that requires letting go of former ideas about oneself, about one’s objects, and about ways of relating to them. To accomplish this, carefully packed baggage of psychological experience is needed, sufficient to begin the movement and sustain the journey.

Adolescence is a time of libido restructuring and gradual separation from parents, when former objects lose some of their containing function. Adolescents begin to seek new objects capable of supporting their intensified drives and emotions.

Puberty—the period of physical sexual maturity and the accompanying physical capacity for procreation—intensifies the process of reliving, reorganizing, and integrating past psychological experiences within the new context of physical sexual maturity.

Former wishes and fantasies, safe and acceptable before the onset of physical sexual maturity, acquire a new, incestuous meaning during puberty. Previous ways of dealing with incestuous desires and fears place a new burden on the ego. In normal development, the adolescent unconsciously maintains confidence that choice exists in their sexual life, that is, the shift from incestuous objects to other relationships.

At the beginning of puberty, there is still a defensive need to reject the new status and to temporarily return to the earlier passivity of the relationship with the Oedipal parent of the opposite sex. This transient passivity or submissiveness of the adolescent includes anxiety and fear of revenge from the Oedipal parent of the opposite sex, while at the same time reflecting the adolescent's wish to remain the object of non-incestuous, that is, non-conflictual, care and love. Normally, Oedipal identification with the parent of the same sex allows the adolescent to overcome this drive toward regression. During normal development, an adolescent can overcome the repression of Oedipal and pre-Oedipal fantasies or desires; otherwise, their ego may become overwhelmed, unable to cope with the qualitative and quantitative changes in instinctual demands.

In the second half of adolescence, the body image becomes sufficiently stable and the adolescent can renounce the protective satisfactions of passive submission to Oedipal parents. This unconsciously frees them to find peers of the same sex as objects of identification and those of the opposite sex as objects of sexual desire. The adolescent must now rely on their own activity—autoerotic or involving a non-incestuous object. Otherwise, puberty is perceived as a demand to renounce pregenital perfection. Idealization of dyadic relationships must be abandoned and genitality embraced, which the adolescent may perceive as a threat to the destruction of relationships with Oedipal objects.

In relation to Oedipal identifications, the new sexual body signifies that the narcissistic investment in the body image is no longer dependent on the mother's physical care. To restore the narcissistic investment in the body, it is necessary to integrate the

mature sexual organs as part of the new self-image. In the *Three Essays on the Theory of Sexuality* (Freud, 1905) Freud writes:

> At the same time as these plainly incestuous phantasies are overcome and repudiated, one of the most significant, but also one of the most painful, psychical achievements of the pubertal period is completed: detachment from parental authority, a process that alone makes possible the opposition, which is so important for the progress of civilization, between the new generation and the old. At every stage in the course of development through which all human beings ought by rights to pass, a certain number are held back; so there are some who have never got over their parents' authority and have withdrawn their affection from them either very incompletely or not at all. (Freud [1905], 2006:24)

The movement towards detachment from parental authority, being the fundamental task of adolescence, inevitably confronts the adolescent with depressive anxiety, guilt, and despair. The adolescent attacks his parents and their relationship, but then "*he may realize that in an act of revenge in phantasy he has attacked and destroyed his good objects, that he and his objects are now devastated*" (Steiner, 2011:135).

This process of separation can be complicated and stalled when external factors specifically intrude into the individual's psychic life. Parental divorce or moving to a new country intensifies the feeling of alienation and guilt over one's own destructive impulses.

Case Study: Ann

I will discuss my work with Ann, a 14-year-old girl whose history of development has been shaped by repeated emotional ruptures, geographical relocations, and parental absence—both physical and psychological. Her inner response to these circumstances gives a picture of how defensive psychic systems take shape.

Ann's early life was marked by instability. When Ann was six months old, her mother went back to work and left her in the care of different nannies. When she was very little, her parents divorced because of her father's infidelity. Ann was often left with family friends, one of whom she once called "mom".

At age of 4 her parents reconciled, and a year later, her brother was born. The family moved frequently, rarely settling in one place for more than two years in one country. At age 5 Ann moved with a certain awkwardness, falling frequently as if unsure how to coordinate her legs.

Ann's mother recalled a brief period of Ann's happy life after the family's reunion, which soon came to an end with the birth of her brother. Ann resumed coming into her parents' bed at night, displaying regressive behaviors.

In preschool and early primary school, Ann showed aggression towards perceived rivals and later behaving similarly towards her brother, whom she openly resented. In primary school, another bullying incident led to her temporary social exclusion by her class.

According to her mother's account and presenting problem, a full emotional separation between them has yet to take place. Ann's mother was concerned about her daughter's emotional fragility, particularly with another planned relocation leaving Ann alone in the country in boarding school.

She also claimed that Ann presents emotional instability, difficulties identifying and verbalizing her emotional experience. She reported Ann struggles to identify her feelings and fears failure - particularly in academic contexts despite high achievements; she fluctuates between functioning with autonomy and reverting to dependent, regressive behavior (e.g., Ann refers to herself as "mommy's baby" and seeks physical closeness).

About six months before the start of therapy, the family moved to the country where we met and began our work. Ann believed this move might save her parents' marriage, which remains highly conflicted. She felt responsibility for their separation, stating that she moved only to keep them together. Her father appeared to be emotionally aligned with Ann's brother.

During the therapy, I learned from Ann that her parents had been expecting another baby who died during pregnancy when Ann was about 8 years old. Ann's mother had herself been deprived of care from her own cold and distant mother, and she had little contact with her father, as they were divorced. This pattern of emotional distance and lack of parental presence was repeated with Ann. She recalled that much of her childhood was spent accompanied by a driver who took her to a wide range of activities (art classes, gymnastics, piano lessons, boxing, and ice skating). Ann rarely stayed at home. It was often her driver, rather than her absent father, who attended her childhood performances.

Melanie Klein provided a definition of the process that provides a connective tissue in the personality. She writes that the basis of a feeling of integration, of steadiness, of inner

security, is the consequence of "*the introjection of an object that loves and protects the self and is loved and protected by the self*" (Klein [1957], 1975:19).

Bion developed Klein's theory, stressing the function of this introjected object, which is essentially to make feelings thinkable, understandable, and therefore tolerable. He describes how necessary it is for a healthy emotional development to have the experience of a parental object (often the mother) who can receive a cluster of sensations, feelings, and discomforts that the child cannot give a name to and is, therefore, unable to think about. The function of this object, defined by Bion as alpha function or reverie, as we have seen, is the one of keeping in the mind, giving a meaning. Repeated experiences of such containment allow the child to internalize this function, gradually learning to manage anxiety within their own mental space (Bion, [1962], 2008).

Pink Floyd's song "Comfortably Numb" conveys a state of comfortable numbness when the pain is so intense that it cannot be endured. When there is no one nearby to hear, because the house is empty. In the song, the child's hands, due to the excruciating pain and the agony of the heat, felt like two balloons. Such hands cannot grasp anything. Balloons can deflate or fly away at any moment. It is impossible to hold on to someone, to cling to another who could anchor and ground you. Hands are essential for a small child to engage in exploratory activity, to be able to crawl towards a goal. The way a mother holds her infant shapes the child's curiosity and goal-directedness.

In Ann's case, her mother was apparently in an absent, depressive state. The frequent changes of caregivers and the lack of external stability of the object led to Ann finding it difficult to establish a goal, to decide towards whom or from whom to crawl. Ann's father infidelities, divorce, and the absence of an internal, good, stable, reliable object within her own mother meant that at times it was difficult for her mother to respond to her child's needs, to be an anchor. To maintain balance, one needs to control the center of gravity, which must not go beyond the point of support. If this support is missing, the body tries to create a new one or to grasp onto something. The sudden disappearance of parents, the appearance and frequent rotation of new caregivers, and constant relocations led to a sense of lacking this support, grounding. The objects she could grasp onto vanished from sight like balloons. Ann felt abandoned by her parents even in their presence. This created

an incredibly strong separation anxiety. Not only did she have no hand to hold onto, but the very ability to hold someone's hand - that is, to maintain a stable connection with another had not developed. All object relationships were imbued with emptiness for her; there was no element of reciprocity. André Green writes:

> We witness a failed experience of separation-individuation (Mahler), when the young self, instead of creating [a psychic] container for the subsequent investments following separation [from the mother], persists in holding onto the primary object, repeatedly reliving its loss, which brings about, at the level of the primary self entangled with the object, a feeling of narcissistic depletion, phenomenologically expressed as a sense of emptiness… (Green, [1980],1986:142-173)

Cancellations or missed sessions felt to her like losing this point of support, a suspension in the air. Once she suggested what metaphor I might use: "*I'll take a paper napkin from the box, toss it up, and you'll tell me—look, Ann, see how this napkin floats in the air, it's unclear where it will land—flying, poor thing, needed by no one*." This reflected her difficulty in holding an object in her psyche: the inability to internalize both parents and the connection between them leads to concretized thinking and difficulties in symbolization. Therefore, she needed my concrete, physical presence. At a distance, due to the lack of object constancy, she would lose me as a good object, and I would become an indifferent mother. At times, she accused me of coldness or of failing to respond to her messages. Between our meetings, especially during long gaps on her part, I became, for her, someone who abandons and does not care.

Ann defended herself against this unbearable feeling of loneliness and abandonment by denying the significance of good objects, devaluing them, and showing contempt. Especially at the start of work she behaved towards me with arrogance, taking a safe position of omnipotence, which protected her from unbearable pain and created an illusion of control over the object.

In the first sessions she told how she hated all "half-bloods" and that at school she talks only to "pure-blood nationalities". She hated people of the nationality that formed the majority in the country where we lived, considering them "dirty, disgusting, stupid, and smelly"—mostly they were people doing low-paid jobs, often service staff.

Entering my room, she could say that it smells of feces. On the wall hangs a painting of a very frightening woman who looked like a wicked witch (Baba Yaga from Slavic folklore)

who reminded her of the previous psychologist whom she had seen regarding her aggression when her mother was pregnant with her third (unborn) child.

When there is a failure in containment, strong defenses are put in place, one of which is the denial of neediness, in order to keep despair locked up as a protection against one's own feelings of inadequacy, helplessness, and worthlessness. She herself felt 'half-blooded'. She loved the books about Harry Potter who was 'half-blooded': half-powerful magician, half-vulnerable human. She used the illusion of the omnipotence, striving to protect her vulnerable, fragile part and to hide it from the outside world. She maintained the fantasy that she had no dependency on or need for anyone. At the same time, she hated those who have to obey and who have fewer rights and who feel vulnerable and dependent on the actions and desires of another. She defended herself with all her strength to prevent anyone from discovering the 'half-blooded' within her. Like Harry, she felt herself an orphan imbued with a sense of exclusion, alienation, and abandonment. These feelings so typical of adolescence can be integrated and neutralized by the supportive environment. Ann, however, rejected and discarded everyone, thereby making the process of emotional processing challenging.

A central aspect of our work concerned her repeated absences from sessions when she left me in a state of uncertainty, anxiety and despair whether she would come. After a series of cancellations when I was almost losing hope, she unexpectedly appeared. It seemed important for her that I was waiting for her never knowing when she would come. Thus, I had become an abandoned, rejected child who has to wait for his indifferent, detached mother to come. "My hands felt just like two balloons": helpless, unable to hold her — she kept breaking away and flying off. She often traveled to different countries, missing sessions, and frequently did not inform me of her departure dates or suddenly moved them to earlier ones, and I hardly ever knew when she would return.

She often brought fantasies about becoming Hitler bringing together all the races she despises – those who usually do all the dirty work and who have to submit to those stronger and more powerful and will burn them. To burn her own need, her *half-bloodedness* or *mishling* – the one who may be expelled and who does not conform. It was appealing to be the one who has the power. Pain, disappointment, anger at helplessness when you cannot

control the object when it is unreachable are replaced by arrogance and indifference. She asked me to remind her about our sessions. With a contemptuous smile, she told me that she had forgotten about me when I reminded her of the missed sessions. In one of her messages regarding a missed session, she wrote to me that everything was fine, that she was visiting (having left again for an unknown period) a relative who is also a psychologist, and therefore 'she already has therapy.' In other words, in her absence, I was meant to feel the jealousy of not being needed, and that what I provided her could be easily replaced, found elsewhere. I was supposed to experience, in a sense, how she felt with her own mother.

The child who cannot understand why she lost the attention and love of his mother, is forced to resort to a defense of disinvestment from the maternal object. In subsequent object-relations, the subject, who is prey to the repetition compulsion, will actively employ the decathexis of an object who is about to bring disappointment. André Green writes:

> The subject's route evokes the pursuit of an unintrojectable object, without the possibility of giving it up or losing it, not to mention the absence of the possibility to accept its introjection into the 'I' invested by the dead mother … the subject's objects always remain on the edge of the ego—not fully inside, and not entirely outside. And this is no accident, since the central place is occupied by the dead mother. (Green, [1980],1986:142-173)

Ann's main complaints concerned the absence of her mother: her physical and emotional inaccessibility. Ann often switched to English during the sessions, mostly when she talked about her affective state. She complained that it was difficult for her to argue and quarrel in her parents' language. It is precisely through the mother's body, her voice, rhythm, and gaze that the child becomes familiar with language. Ann's sense of alienation was exacerbated by the absence of a consistent object capable of putting her experiences into form through language and integrating them into the structure of her identity. She could not express her feelings in her mother's language - she lacked such experience.

Her parent's divorce could be felt for her as a kind of triumph – an opportunity to stay in the pre-Oedipal mother–child dyad, avoiding the need to move toward the more mature, triangular relationships. In this position the female object becomes not only the figure of attachment but a symbolic retreat where she can place herself in a regressive form,

maintaining the illusion of symbiotic wholeness. She is characterized by marked resistance to the process of growing up, accompanied by fantasies of remaining in the mother's womb and a fear of being expelled.

Ann's infantile needs, her longing for a love object, are condemned by her and experienced as shameful and humiliating, since they were unconsciously linked to a desire to return to an idealized prepubertal state and to a rejection of her new sexual development. In our work, she suspected me of "vacuuming my head" when she leaves, to make room for some other, more fortunate rival. She fought for a place in the mother's womb and is afraid that someone else will take her place, then it is frightening and anxious to separate from her. Her anger and envy of the child, who could get from the mother what she herself so lacked, led to a persecutory sense of guilt for the damage caused in her fantasies to the mother and the rivals in her womb. She had a fantasy that there was a part of the dead baby inside her - the part from which it was impossible to rid oneself and to repair this dead internal object.

In one of the sessions, when she, contrary to usual practice, saw me outside the office, she remembered the film "The Notebook" she had recently watched, over which she had cried for a long time. It was unbearably painful for her to see how one person forgets another, feeling nothing towards her loved ones, making them suffer. I said that she was worried whether I remembered whether I thought about her and about our meetings when we did not see each other. She answered, "*Thank God, I do not love you, otherwise I would have died. If this happens to me (about memory loss), then I want euthanasia right away.*" She could not imagine being together, living together, "going on a trip" in therapy together – something with an element of reciprocity. Therapy motivates her to this reciprocity, which causes the strongest anxiety and fear of loss.

In the middle of our work, she suddenly asked my name, saying that she only knew my last name. In the same session, she told me about how a piece of material from her braces was left in her tooth during the surgery: "*They opened it up twice, so I don't know who forgot it, but now it hurts all the time when I chew*." She is unable to awaken, to reach out to the "dead" mother, which "*causes a furious helplessness... an outrageous situation*

that reactivates the loss of narcissistic omnipotence and evokes a sense of her own incommensurate libidinal wretchedness" (Green, [1980],1986:142-173).

She felt like a "foundling": she was abandoned to different families when she was little, and now it was as if she had been abandoned to me so that she would not bother her parents. It was difficult to build relationships in such a situation. The indifference and forgetfulness of another person had left a large, constantly reminding wound that feels like something dead, stitched up inside. When you are forgotten, you have difficulty digesting new food. Entering into a new relationship, investing in it is a big risk of being abandoned again, facing unbearable pain, actualizing the narcissistic wound. She needed stability, but she did not associate it with other people. On the one hand, she really appreciated someone who was interested in her. On the other hand, she immediately began to devalue, because she was afraid of being inadequate, losing contact - if we were going to break up anyway, why get attached.

At one of the sessions, she told me about her exam: "*I wrote everything wrong. There I had to describe the structure of the eye, and then how the pupil reacts when something is far away and when an object is close, when it is dark and when light suddenly appears. I think I wrote that it dilates in bright light, but I should have done the opposite. Mom says: just memorize it, - but I can't do that. Here you can't just learn by heart about vaccinations. For example, when a dead agent is introduced, the body reacts to this by immediately attacking it with a bunch of phagocytes and leukocytes. Well, that is, the immune system is activated. But at the exam I will get a ticket that says this is the situation: a child broke his leg, ended up in the hospital, they give him a lot of drugs, can he get a vaccination in this case. I can't just scram, I need to understand so that I can apply it later in different situations*."

On the one hand, she perceived therapy as a potential "vaccination" – as a protection of her psyche. When we saw each other, when we were physically close, she felt that I looked at her in one way: she felt my interest. But when I was far away, my gaze changed for her. The setting, our limitations, my absence were perceived by her as this dead agent – a collision with this dead object. And then, coming to the sessions, she reported on this terrible woman on the painting, on unpleasant smells – a good object was not preserved,

but spoiled. Therapy for her was like a vaccination of a wounded organism – it entailed an uprising of defensive mechanisms. Her psychic “immune system” was kept in a mode of readiness for attack, so any approach to a living emotional experience was perceived as a threat of destruction. This is similar to a psychic autoimmune process. The main problem in the autoimmune process is that the leukocytes stop distinguishing between "self" and "foreign" and attack healthy cells of the body. After the leukocytes, such as phagocytes, recognize their own cells as hostile, they begin to destroy them. Thus, in the case of autoimmune diseases, phagocytes, instead of protecting the body from external threats, actively participate in its destruction. In my absence, her psyche perceived me as a "bad object": indifferent, dead, bringing only pain. Then she attacked the very possibility of help that she could receive from me. By skipping sessions, being late, resorting to arrogance and indifference, devaluing the significance of our sessions, she “rejects” the benefits that could be integrated, turning potentially good food into dead objects. She often laughed at my interpretations: “*Can you connect everything? Again, your metaphors*?” As if the very meanings that I offered become “foreign agents” for her. Her irony and skepticism acted as a defensive mechanism, as a psychic 'rejection attack' directed against that revival, that which might prove intolerable, threatening the fragile relationships with both internal objects and external figures. She noticed the slightest changes in my office, insisting that my chair be placed exactly as it was the previous time (the chair had been in its usual place), turned toward her at precisely the same angle as before. On one hand, this revealed her wish to keep everything unchanged, to reject any possible alterations, her striving for a state of calm and the elimination of stimuli, her emotional retreat. On the other hand, envy toward me, toward what I could give her, turned into greed and the wish to control me as a good object she depended on: *“If I were a president, I would lock you and this office with a key so that you would communicate only with me*.” To lock someone up with oneself means to enter into and hold on to a relationship. What troubled her, however, was the fear of what might happen if such violence toward the object was not exercised — would it then disappear for good? She wanted me to remain seated, waiting for her, while she was a free bird — flying in only when she pleases. Thus, she projected the feeling that the other could disappear at any moment onto me and left herself a position of freedom and independence. Her indifference,

forgetfulness were protections from the unbearable fear of becoming attached and being abandoned. The image of someone who abandons, who has power, was attractive to her. It was unbearable to be the one who is forced to obey and wait. The feeling of inevitable separation and the fragility of the relationship was confirmed by external factors: from the very beginning, face-to-face work had a limited duration as she had to leave to another country to study.

Throughout the work I felt sympathy for her, waited for her, and despaired when she did not come. It seemed that I needed her more than she needed me. I was very glad when she came, often catching myself looking at the clock while waiting for her. For her, it was important to relive the experience of being cared for. In my countertransference, I felt that she wanted me to look at her the way a mother looks at her infant, to keep her at the center of attention. I sensed her need to be liked, to be visible, to see herself reflected in my eyes like in a mirror—as a beautiful young woman. She had a desire to possess an attractiveness that would gather everyone around her, and sadness about the fact that she could not unite her father and mother around herself, that she failed to keep them together. She felt like the apple of discord and therefore wants to diminish herself to a minimum in order to stop being an irritating factor for everyone.

On the wall of my office hung two paintings by Andrew Wyeth: one depicting a woman sitting in a doorway, gazing into the distance, and the other a window with a seashell lying on the windowsill. Ann often remarked that the woman was too thin, long-nosed, resembling a witch. She once said that I scared clients away with such paintings, and that it would have been better if there had been a mermaid in the second one.

The tale of the Little Mermaid describes the coming-of-age story of a teenage girl—her painful transition, the crossing of borders between the child's and the adult's world. The longing for the prince symbolizes the shift of libido from the family world into the outside world, the search for a new, non-incestuous object of love. It is a step toward mature sexuality and autonomy, a step out of the "underwater" world of incestuous fantasies into life in one's own body, one's own sexuality, and new objects. The tale portrays the process of separation, of growing up, the search for one's own identity and language, as well as the pain and fear of the bodily changes taking place. The transformation of a tail into legs is

painful: "You will gain human legs, but your walk will be as painful as if you were walking on sharp knives. And, what's more, you will lose your voice, because when you drink the potion, your tongue will be cut out." A tail limits movement; it is necessary to "grow" one's own legs to gain support, autonomy, and the ability to act independently. An anxious and painful step away from parental figures and the parental home, toward the possibility of breathing and moving independently. The transformation of a tail into legs is necessary for autonomous living and mature reproductive function; it is a move toward adult identity, the ability to bear children and form relationships outside the family. The Little Mermaid loses the ability to speak—the changes in her body and separation from her parents lead to a painful state of mental isolation, in which it becomes very difficult to express or comprehend all the new sensations that arise. The key emotional elements are alienation and loneliness.

Ann's containment objects proved too distant to help her through this separation catastrophe. Knowing who one is and where one's origins lie allows one to move from the comfortable world of childhood, where everything is arranged by one's parents, without a disorganizing rupture. Without this knowledge and support, however, the adolescent becomes doubly vulnerable to the challenges of puberty. Ann felt like she belonged nowhere, unconnected to anyone or anything, stuck on the edge. She did not feel like the world she lived in was her own.

Brady (2015) says,

> The adolescent is caught in psychic isolation in many ways—caught in an awareness of things one is not ready for yet. Caught in sexuality and gender being more defined and intense, gone is the 'uneasy truce' of latency. Caught in a body transforming seemingly with a will of its own, caught in inexorable changes with parents, or parental figures … and caught in the impending challenge to define a role in the larger world. (Brady, 2015:179-194)

Ubbels (2012) states,

> For development to continue, subjective experience of one's agency and autonomy is essential. Autonomy means the ability to choose — to be active or passive, to grow or to remain small — and that one position in these dichotomies does not exclude the other. Reality becomes more visible, for example, two properties of an object are connected in a logical relationship and causality, as when a child begins to understand the action of a lever... children notice that their view of reality is changing, their parents are changing too, but they can be returned to." (Ubbels, [2012], 2019:21).

Ann could not feel her individual activity. The task of our work together, as I saw it, was to show her that she had her own trajectory of movement. She needed to understand who she was in the family system, what contribution she made to it. She found it difficult to feel her own agency — in this family everything was confused, she was involved in the family conflict, where it was impossible to feel her separateness, her zone of initiative. Everyone forgot everyone else**,** and she forgets who she is, in what coordinate system. When she came to me, she explored the space: how the doors in my office opened, how she got there and entered it, how I was sitting toward her. All of this was her exploratory activity: what would happen today. She felt like a person without a future, she needed the opportunity to feel, to fix herself in the present moment, she was very dependent on the current state of affairs. She needed me to be a mirror, describing what was happening to her, who she was, what she was like. It was important for her that we kept a "notebook" in which her experiences, the history of her life, would be recorded and stored.

Coming to a session, she would sometimes check her chair, it seemed to her that someone had sat on it or that I had replaced it with another one while she was gone. In this way, she checked who was in the office in her absence, whether there was still room for her in my head. My office was in a business center, where there were security guards who required identification to get inside the building, to get to me. She often complained about this requirement. For her, this was a requirement to present her identity in order to enter - both the building and the relationship. But she faced a difficulty, she did not know with whom exactly to identify herself. There was a broken, fractured parental couple, a fragile mother who was abandoned by an all-powerful and unavailable father. An underdeveloped sense of her own identity deprived her of the necessary emotional equipment to maintain a mutual relationship. To be able to love someone, one needs to feel that one exists at all, and she often feels dissolved in the parental conflict, the reasons for which were never clear to her. Why they broke up, why they got back together, how she influenced the fateful decisions of the family. She was overexcited, irritated, overstimulated by the change of people who pounced on her with their experiences. Therefore, it was so difficult for her to

focus on her inner world that she brought countless stories about her family to sessions. It was important for her to be recognized within this overall mass of her individual qualities.

Like the painting she hated, depicting a woman sitting in a doorway — neither inside nor outside — Ann was stuck on the path of growing up, at the transition to adult life. Ann's need for independence, her wish to attend boarding school, was, on one hand, a normal developmental stage, and, on the other, a means of avoiding guilt stemming from her aggression and envy. Ann experienced enduring guilt over the breakup of the parental couple; separating from such a fractured pair was profoundly difficult. She perceived her separation as an attack on them, which was why they are falling apart — a perception that was very concretely confirmed in reality. What should have remained a teenage fantasy became concrete and real for her. During our work, Ann's parents divorced for the second time, again due to her father's betrayal. Unrepressed incestuous fantasies continued to haunt her, and her only recourse becomes flight—she went to boarding school in an attempt to escape this incestuous space. This escape became not only a means of survival but also the only possible path for her development, a chance to find her own place and identity.

Ann was forced to relive once again the feeling of being left without parents, without a family, in the context of another divorce and her move to another country. Speaking about the guardian in the new country, who had several other wards besides her, she used the term 'orphanage.' She found herself in a lonely position, surrounded by nothing—no home, no parental couple, no connections, no one to turn to. This sense that there was no one and nowhere to return to hinders her development. She felt no love from anyone and was angry that I could not help her turn her parents back toward her. Ann had the fantasy that her parents abandoned and disappeared from her life because she was too unpleasant. To compensate for the feeling of her own unattractiveness, she strived to possess valuable things, which she believed will create a beautiful and desirable shell for her. She insisted that her father give her the most expensive gifts — they are meant to confer value and attractiveness where it is lacking inside. However, the attempt to fill the inner emptiness with external objects proved futile: her father was unable to respond to her true needs. As André Green writes, *"Thus the subject finds themselves trapped between the mother — dead — and the father — unavailable*" (Green, [1980],1986:142-173).

This was the state of a fetus frozen in the womb. She perceived her separation from her parents as a miscarriage, which caused an agoraphobic feeling. On the other hand, remaining in this womb meant not having the opportunity to develop, to be this frozen fetus. Her parental couple was split: an all-powerful rich father who abandoned everyone and a fragile, vulnerable, physically and emotionally absent mother, dependent on his money. Adolescent crisis involved devaluation and separation from parents. However, separating from such an omnipotent father figure, a grandiose figure, proved impossible, as it was impossible to communicate with him as with an ordinary person.

Klein writes that to reduce a child's early omnipotence, gentle reality testing is necessary, which softens it and gradually leads to a transition to more realistic relationships with objects (Klein, [1959], 2019). Reality testing confirmed the existence and safety of the good object, reducing anxiety about it and the need for obsessive control. If reality brought too much frustration or loss, the child may revert to omnipotent fantasies to protect against feelings of helplessness and dependence. For Ann, the confrontation with reality was too abrupt and painful, so the manic defense of omnipotence remained especially attractive, helping her cope with the pain she experienced and the feelings of helplessness and abandonment.

Strong feelings could be dealt with if the teenager has the Other who was able to perceive and make sense of his intense experiences, or if there was a connection with an inner part that could give meaning and restore order. Ann lacked both external and internal objects for establishing contact. Moreover, she was forced to be drawn into family dramas. In recent months, she had often complained about the absence of a “home”. For her, a home was also a symbol of grounding, a container, a holding, a physical counterpart to the psychological function of the family. The absence of such a place was experienced as disorientation, chaos and loss of structure. On one of the sessions, Ann described how, while preparing for her exams, she had great difficulty organizing cards and tickets in a way that made sense to her. She asked that no one touch them. However, the cleaning lady came in and tidied up, collecting them all in one pile. For Ann, this situation was a repetition of her inner experience: her efforts to create meaning and structure were devalued by the intervention of another who, instead of supporting her, introduced confusion and chaos.

Thus, the objects in her inner world are experienced as disorganizing and destructive rather than as containing and protecting.

She constantly found herself in a situation of instability, inaccessibility, and fragility of her objects, making separation from them difficult. As a defense mechanism, a state of "comfortably numb" arises—a mental anesthesia that temporarily shields her from the overly strong influence of the instability of her inner and outer worlds. Ann needed space for development, a space separate from the family drama. The inner space of *terra nullius*—a state of lack of identity, an unnamed land belonging to no one—is a transition space in the process of her development.

In order to initiate the process of subjectification, the emergence of her own identity, and defrosting, it was necessary to populate this deserted land with new objects. Over the course of therapy, Ann gradually became able to separate herself from the tangled family system; adolescent conflicts and maturation became more prominent and accessible for processing and integration. She gradually emerged from her state of emotional freezing, from being “comfortably numb”, and a caring object is being introjected: she had become more attentive and considerate of others. She guarded the feelings of a boy who asked her out for a long time, not wanting to hurt him with a refusal. By skipping sessions, she transformed our work into a desolate, uninhabited land, lacking clear boundaries and stability.

At first, she introduced me to this territory, testing its safety, probing its boundaries. This was an opportunity for her to experience someone else's presence on the island without threat to herself, without the fear of the territory and its inhabitants being taken over by alien objects. Only after being convinced that this land was habitable, she landed and began to explore it. *Terra nullius* thus becomes a space of subjectification: the teenager takes responsibility for her inner space, names it, populates it with objects, and builds stable boundaries, turning what was once a no-man’s and unstable land into a settled territory that belongs to her.

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Between Infant Observation and Psychotherapy

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"Let us listen and not be preoccupied of keeping anything in mind"

(Sigmund Freud, 1912)

Infant observation[1] gives us a broader view than dreams and the material emerging from therapeutic work with adult. It also provides a more precise knowledge about the earliest stages of the development of the mind, the primitive form of body expressions, and the very

1 "According to Esther Bick's method (1964), Infant Observation consists in observing, once a week for an hour, the development of a newborn baby within the family, from the birth to until the age of two. Afterwards, the observer writes what was observed, trying to remember as many details as possible. Then the material is read, discussed and processed during seminars in a small group with a specialized leader (psychoanalyst or psychotherapist having a personal experience of the Infant Observation) and the other observers. The method features three main stages: 1) the observation of the baby within the family; 2) the subsequent written reports of the observations; 3) the supervision seminar in the small group, following a sequence that leads the observation from a phase of annotation to a level of initial inferences, and afterwards to the formulation of meaningful concepts in relation to what has been observed to reach a dynamic understanding of the interaction. This observation id defined "participated" because the observer has a neutral and participating position at the same time: the observer is the witness of the uniqueness of the situation that is unfolding before his/her eyes and pays attention to his/her personal experience. It the use of the observer's countertransference that offers an effective basis for a direct knowledge of the development, as it helps in grasping the emotional meanings of interactions and behaviour" (Ferrara Mori, 2015, pp. 6-7).

early forms of thought, which, for some adult patients, might be the only accessible form of thought. In addition, they represent the relational background that pervades the emotional field between patient and therapist (Bick, 1964; Winnicott, 1989; Magagna, 2005; Urwin & Sternerg, 2012).

Both infant observation and psychotherapy produce meaningful material upon which it is possible to think about. Like psychotherapy, everything that takes place in infant observation is never ordinary but highly involving and meaningful. In both situations, we are dealing with the inner mental life and with unconscious processes having their own structure and movement (Magagna & Segal, 1989).

However, infant observation allows us to grasp the very beginning of a process defined "the primitive edge of the experience" (Ogden, 1989). Psychotherapy through dream work reconstructs "the historical truth" or even better " the narrative truth" (Spence, 1984). It deals with words, feelings, meaningful representations. In a different way, infant observation deals with the "beyond the visible" which can be gathered beyond the manifest behaviours.

> Finally we wish to highlight the observer's function as container of anxieties and provider of a capacity for interested attention in the mother-baby dyad. We think that this model can be transferred to the analytic situation where in the course of the process the patient will have many opportunities to identify with the analyst's attitude of interested observation of his mental states. This is part of the development of the psychoanalytic function of the personality. It also provides the patient with a model that guides him to develop his own capacity for observation, and to be able to collaborate more closely through providing his own intuitions, which in the analytic dialogue become new hypotheses in a potentially infinite spiral. (Borensztejn et al., 1998, p.82)

In order to make sense, infant observation traces "the precocious", the earliest interactions between the individual and the environment, while psychotherapy traces " the depths".

> Whoever undertakes infant observation must be prepared to believe that the analyst can formulate concepts on the early infancy which can be psychically true, although not demonstrable. Through direct observation it is possible to demonstrate that what has been noticed in the analysis cannot possibly exist at a certain time of development because of the immaturity of the infant (....) Further investigations bring us to the instinctual roots of the individual life, although they do not tell us anything neither on the normal dependency nor on the dependency which did not

> leave any trace on the individual despite it has characterized the first period of life. (Winnicott 1965, pp.141, 143)

What differentiates the observer from the psychotherapist is their specific tool. While the observer has his own "observing mind" which together with the statements "do not act" and "listening" provides an experience which is similar to the gradual formation of an interpretation in the psychotherapist's mind within the session, the analyst has also at its disposal the interpretative tool, with its own transformative capacity.

Within the observation setting (Genovese, 1993) we can see two different moments one of which is external to the emotional atmosphere of the observation itself. The observation so reconstructs a triadic situation, in which the third element may could be an overview of the relational history (the intersubjective analytic third).

> The mother-infant unity coexists in a dynamic tension with the mother and the infant in their separateness. Similarly, the intersubjectivity of the analyst-analysand coexists in a dynamic tension with the analyst and the analysand as separate individuals with their own thoughts, feelings, sensations, corporal reality, psychological identity and so on. (...) from the point of view of the interdependence of subject and object, the analytic task involves an attempt to describe as fully as possible the specific nature of the experience of the interplay of individual subjectivity and intersubjectivity. (Ogden, 1994, p.4)

Sandri (1999) turns to the image of the mother breast-feeding her baby as a metaphor of the relation between the therapist and the patient. As the mother adapts herself to the needs of her baby, the therapist approaches each patient with a different intonation of his voice, a different attitude, and a different non-verbal expressions. Each couple, mother-infant, therapist-patient, tends to create its own personal common rhythm, first form of a dialogue, an emotional synchronicity which reminds of a musical duet or an orchestra sonata (Stern, 1998). The sucking rhythm, the emotional relationship with the parents both at sleep and waking time are very important to the construction of an inner time within the baby, a very primitive psychic time, a music grammar.

Similarly, "in addition to the requirement of polyvalence as described by Bion (1977) an interpretation, intended in such a way, has the requirement of polyphony too. [...] elements such as the tone, the colour, the musicality of the voice together with the linguistic

form of the interpretation" (Bezoari & Ferro, 1990, p.1045) provide to the transmission of the emotional attitude of the therapist.

> As we formulate a theory and in our clinical practice as well, we must try to compose a piece of music rather than just playing notes. In order to reach this aim, we can only accept that words or sentences have not fixed meaning. The sound is possible to change at any time and it is no longer the same or does not mean the same thing. (Ogden,1997, p.8)

Observational and Clinical Material

"The mother knows how to handle her baby....just being there and being able to get rid of his distress (such as air in his tummy) arouses positive sensations that I can recognize through the baby's facial expressions: first he cries, he is tense and restless, then he becomes drowsy and blissful...I have observed the breast feeding three times. It always takes place very rapidly as the baby clings to the breast and sucks it in a greedy way, acting very energetically to get the milk. As soon as he grasps his mother's hand, he finds out the sucking rhythm. He does a rhythmical movement on his mother's hand, as if playing piano, together with a slight vocalisation which stresses the amount of energy he needs to feed himself" (3-month-old baby).

The earliest patterns of the mother-infant relationship such as rhythm, synchrony and reciprocity allow the formation of the projective and introjective processes creating the infant's mental life. Within therapeutic work stability and rhythmicity are also key elements.

> By becoming reliable it is the only way to undertake our profession. The point is that if we are reliable (professionally) we protect our patients from unpredictability. This is exactly what many of them have suffered from, having been subjected to unreliability throughout life. We can not afford to be part of that model. (Winnicott, 1986, p.118)

An environment, either the dyad mother-baby or the dyad psychoanalyst-patient, needs to offer sharing, containment and support in a continuous and stable manner, almost "monotonous" (Winnicott, 1965).

"I have just started to trust you... It took me two and a half years...at the beginning of the therapy I wondered how you could remember perfectly what I had told you...now I consider it as a normal thing...now I am very happy when I manage to name

sensations I feel inside me...there is a difference between "trusting" which can be a matter of a moment and "to have trust" which is a stable and lasting condition" (27 year old patient).

The therapist and the patient go towards each other each in a synchronised way, the movements are almost the same apart from slight variations depending on the emotions of the moments. They both settle down in their own seats, there are silences, words, sometimes body sounds like the rumbling of the stomach coming from one or the other. Other sensory elements are added: the daylight or the artificial light, the noises coming from inside or outside the room. A particular atmosphere is created, where the sensory, emotional, verbal and non-verbal elements all together contribute to create a common dialogue, beyond words (Sandri, 1999).

These same elements also organize the mother-infant relationship and the infant observation setting: there is a common rhythm between mother and her baby just like the rhythm between the observer and the mother-infant couple. The acquisition of a common rhythm represents for the newborn an early form of dialogue, one of the first predictabilities allowing time to appear on the psychic scene.

"The twins sit in front of their mother who spoon feeds them alternately with a teaspoon. She tells me it is a banana food they really like. First she spoon feeds Ludovico who seems to like it very much, then Alessio. Today the mother is very calm and so are the children. She tells me she is very happy as they slept through the night without waking up. The twins are calm waiting to be spoon fed, each of them waits for its own turn opening his mouth a few instants before her mother approaches the teaspoon. They follow the rhythm of their mother's movements perfectly" (4-month-old twins).

"I remember what you told me last time. I have been thinking a lot about it....it is nice to think about things we say here... (she looks at her watch and looks at the therapist, smiling) we still have five minutes, may I ask you what I could think about when we are not going to see each other?" (17-year-old patient).

The "garden of mind" (Vallino, 1997) requires "a particular care, an attentive dedication" to share and contain the joy and the pain characterizing the beauty and fragility of emotions: if the beta elements are adrift and are not contained and transformed,

powerful walls and brushwood hide the garden making life in there cold and barren" (Monti & Fanti, 2000, p.184).

Sometimes the disturbing beta elements, which cannot be metabolized, can congregate in the self, produced sensations and collapse in the contiguity subject-object originating "a sense of self as sensory surface"[2] (Ogden, 1994).

"Getting around by crawling, Alessio goes near the radiator. He seems willing to reach it. When he gets close enough, he starts banging his head against the radiator and the wall of the radiator starts to vibrate producing a brazen sound. Alessio carries on playing in a rhythmical way: he gets closer to the radiator and bangs his head against it, than he moves away and within a few seconds he gets closer to the radiator again. Ludovico sits against the wall on the opposite side of the room but the sounds produced by the vibrations catches his attention. He gets closer to the radiator, looks at his brother and he starts playing in the same way. Their mother tells me they quite often behave in such a way, and she wonders why they do not feel any pain. She thought they enjoy the vibrations, the brazen sound. She tells me they are both able to recognize the radiator. They never bang their head against the wall as they would definitely hurt themselves" (10-month-old baby).

"I squeezed the spots on my face and now it is ruined [...] I bang my head against the wall, I hurt myself, but I need to do it.... I feel such a pain inside that the physical pain soothes me" (26-year-old patient).

Baby's actions speak, without words, to own mother ant to observer about his sensorial knowledge of the world, sound and touch, his movements are a communication of his development. The patient's actions, instead, seem to be looking for someone who can hold her silent, psychic pain, written on her painful skin.

> Analytical process could be relatively simple and straightforward although very tiring. Nevertheless when projective identifications of patient are met with projective identifications of the analyst it is possible to get a phenomena of unconscious collusion which tend to paralyze every movements towards the mentalization and the insight. (Bezoari & Ferro, 1989, p.1035)

2 In Thomas Ogden's psychoanalytic theory (1994), the autistic-contiguous position describes a primitive psychological state focused on sensory boundaries, where a "collapse" signifies a terrifying loss of self-cohesion, felt as falling or leaking into shapeless space. This collapse reflects an anxiety of the dissolution of the skin surface as the basis for the self, a core fear in this mode of experience, crucial for understanding early development and psychopathology.

"Alessio starts crying, first quietly then more and more loudly. His face goes red and he starts rubbing his cheek with his little hands. His mother gets closer and gently picks him up. She starts cradling him. He keeps on crying; nothing can soothe him. He seems to be overwhelmed by an unbearable pain" (4-month-old baby).

"She gets in and tells me, hiding herself behind her hair, that the light in the room it is too strong...she came because her anxieties. She cannot contain them any longer, she does not know how to cope with them... she is worried of not being able to control her hands as she speaks" (26-year-old patient).

The features of polyvalence and the polyphony (Bezoari & Ferro, 1989) improve the transformative capacity within the analytic work and infant observation. On the other hand, the beta elements, inside the analytic third, can obstruct the narrative function of the mind. The analytic third (Ogden, 1997), the observer as a third, can play a transformation role paying a special care to the "garden of the mind" sharing and containing the beauty and the fragility of the emotions which are the first organizing elements of the emotional development.

The mother's face reflects the baby's needs, allowing the infant to feel "seen" and to create a sense of self: the child goes towards the world, but first the world goes towards the child (Winnicott, 1965). In the same way the patient request constant care so that the garden of his mind can flourish again.

"*His mother asks him to let me see how much he loves her. With his fingers he shows just a bit, then suddenly he opens his arms and makes a wonderful smile which means "a lot*" (22 month old baby).

"I have found a magnificent book I can use to work with children, 'The secret garden'....it is really beautiful...I was identified with one of the two children. It is the story of two children who are said to be suffering from a nervous disease. They were cured through their friendship and the friendship with another child ....they discover the nature, life outdoors... as the little girl finds out...they live in a castle which belongs to the girl's uncle and there is a secret garden....the moral is about the secret garden which must be discovered by not being kept closed, inaccessible" (27 year old patient).

In order to gain a shared rhythm and the notion of time we always need two elements at least: a sound and a silence; a movement and a pause; a presence and an absence. This duality refers to the mother-baby dyad which is only apparently so as the phantasmal father enters very early on the psychic scene, long before his presence brings the feeling which structure the Oedipus. The father enters the mother-infant dyad "in secret" (Mancia, 1994) through the psychic reality of the mother herself.

It will be the mother's past experience, with her own internal objects and her representations of a father who might be present, absent, loving or sadist, to allow "the third" to enter in the very primitive relationship with the baby:

> If a mother is dominated by symbiotic and confusing patters which do not allow the infants separation and disindentifacation or if instead she is able to favour these processes in the infant, helping him to come to term with his Oedipus drama, very much depends on the role the father. In which way (with his presence or his absence), he has been able to support the couple mother-infant facing with the anxieties and the mental pain of this delicate maturative process. (Mancia, 1993, p.32).

"I had the chance of meeting the twins' father only once in one year. Despite his absence, he was very present in the mother's words and his presence could be felt at home...The father welcomes me, greeting me as if we had already met ...he immediately asks me about the twins, how they are as I have seen them right from the beginning... the mother allows father's presence not only within home but particularly in my mind and in the twins" (11 month old baby).

"Now I feel happy as the therapy is coming to an end. When we decided it, I was a little bit afraid...Do you remember my nightmares?... It was very important to get my father's support not only when my mother fell ill but afterwards as well...even now it does not leave me alone" (25-year-old patient).

One could wonder what the psychoanalysis' paradigm is about: whether it is an après coup, of the dream or rather the 'hic et nunc' of the infant and what can be seen within the session (Green, 1996). Just like there is no newborn without his mother and his maternal care, "there is no such a thing as an analysand apart from the relationship with the analyst, and no such a thing as an analyst apart from the relationship with the analysand" (Ogden, 1997, p.86).

In this sense, when we observe the mother and the infant together, we try to understand the relationship between the two and the ghosts too, which are within the mother when the child is young and within the child when he has grown up (Balconi, 1980). The vertex[3] from which one looks when faced with carefully observation of the child or infant development would seem to be a fruitful one for discerning later on the presence of the child within the adult, an essential nucleus of analytic work with adults (Harris, 1993, p.97).

"*Sometimes I worry my obsessions will come back and that I won't be able to do anything but to brood... then I think of you and I imagine you telling me 'Berta, how omnipotent would you like to be? Do you really think you have such a life and death power ?!! and I smile"* (25-year-old patient, last session).

> (…) both analyst and patient contribute and share an unconscious intersubjectivity. Paraphrasing and extending Winnicott's statements, there is no such a thing as an analysand without an analyst; but analyst and analysand are at the same time distinct individuals, each of them with one's own mind, one's own body, one's own history and so on. The paradox must be "accepted, tolerated and respected and (...) not solved. (Ogden, 1997, p.86)

The observation and the interpretation can in this way meet and differentiate mutually and be helpful to each other.

> Psychoanalysis has a lot to learn from those who observe directly infants, mothers and infants together and young children in their environment. But the direct observation itself is not sufficient to build a psychology of the early infancy. Lasting collaboration between psychoanalysis and direct observers might be able to correlate what is profound in the analysis with what is early in the child development. (Winnicott 1965, pp.143-144)

Winnicott, in his theory on primitive[4] emotional development, highlights the importance of "continuity of the human and non-human environment", of "reliability", of the transition from "an alive adaptation" to a progressive de-adaptation", and finally the importance of "the measures to realize the child's creative impulse", which is his true self and his uniqueness. This way, the relational matrix can answer the child's needs at the right

3 Vertex is a mathematical term used by Bion (1965) as synonym for point of view.

4 In The Collected Works of D.W. Winnicott, edited by L. Caldwell & H.T. Robinson, published by Oxford University Press (New York) on 2016, the term *primary* has been replaced by term *primitive* that more closely reflects a quality of psychic experience.

time: the relationship with a “good-enough” mother / a “good-enough” therapist allows the child/patient to “spread its own wings”, to feel itself and the other as unique and precious (*a real individual who feels real*).

> *"Who are you?" asked the little prince..(...) " I am a fox", the fox said.*
> *"Come and play with me", proposed the little prince. "I am so unhappy".*
> *"I cannot play with you," the fox said. "I am not tamed."*
> *"Ah! Please excuse me," said the little prince. But after some thought, he added: "What does that mean ‘tamed’?"*
> *[...]*
> *"It is an act too often neglected, " said the fox. "It means to establish ties."*
> *"To establish ties?"*
> *"Just that," said the fox. "To me, you are still nothing more than a little boy who is just like a hundred thousand other little boys. And I have no need of you. And you, on your part, have no need of me. To you, I am nothing more the fox like hundred thousand other foxes. But if you tame me, than we shall need each other. To me, you will be unique in all the world. To you, I shall be unique in all the world…"* (Saint-Exupery, *The little prince*)

> We have all been lions-cubs; and yet we are able to feel the lion in ourselves without fearing that we will need to live in a cage. You see, the difference between the human animal and the lion cub is not that the human lacks appetite but that the lion lacks imagination. (Winnicott, 1952, cit. in D.W. Winnicott. 2025, p.56)

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Study Day Section

Child & Adolescent

Ghosts Unheard and Shapes Unformed: The Necessary Challenges of Working with Internal Parent-Child Representations in Child Psychotherapy

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A Psychoanalytic view of children's development holds their parents as integral parts of their unconscious lives. Research into early attachment and parent-infant relationships is revealing how the unconscious ideas that a parent forms around their child can begin around conception, pregnancy, or even in-utero. This internal representation of the child, whether blurry and inaccessible, or imbued with unconscious aspirations, comes into being in the parents' minds. This continues, as real-life experiences of pregnancy, following into birth and the early years of the child, contribute to this internal representation.

Parents' own emotional lives, whether affected by external, social factors, or intergenerational trauma, or more ordinary developmental experiences of being in a parent-child relationship themselves, gather together to form an unfolding, live picture of their child. I say parents, plural, throughout, not to signal to a parental couple, but to refer to parents as a clinical group, which includes single parents. It is unhelpful for parents and their children when these internal representations cease to be fluid and developmental and can instead become entrenched and rigid. This rigidity can find validity in external frameworks, such as categorical depictions of behaviour, which reduce the child to narrow descriptors. At times, these descriptors are treated as symptoms and collapsed into diagnostic labels. The

balance between ordinary developmental struggles and experiences can tip into a cauldron of unconscious phantasy and darkened trauma, which can be hard to find a way out of, for parents and children alike.

Trauma itself can skew the course of ordinary development and interrupt the setting up and mapping out of a child's internal world. When it comes into a family situation, trauma can sear fault lines or ruptures within a parent-child relationship. This may deprive both parents and children of the opportunity to be freed up to access the warmth, hopefulness and joys, as well as ordinary frustrations, of developing a relationship which swells into growth and integration and share in the experience of developmental gains.

Psychoanalytic thinking views parents and their children as inextricably linked to each other, even within external realities such as absence, separation, abandonment. For it is their internal worlds which weave the fabric for this connection. This inextricable internal, relational link is happening within the parent themselves, within the child themselves, and so too a version of a connection between them both is present and mutually influential in live, external reality. These interrelationships mean that it is imperative in our work as Children's Psychotherapists, to work with their parents.

Our toolkit of Psychoanalytic observation, listening and awareness to symbolic, unconscious meanings, with a capacity to nurture relationships, must be put to work in relation to parents, in the service of our work with the child. I say in relation to parents, because our work with them can be incorporated into our work to help the child in different forms. It can vary from direct work with parents alone, without ever meeting the child, or prior, during, and after the child's individual Psychotherapy, to working with them as part of the child's sessions. Parents might be physically present in the consulting room, or symbolically, in children's communications via language, signals, exchanges and play.

The foundation for our thinking about how to structure our work with parents and children starts from how to support the child's needs. Parent work may be secondary to this primary focus, but it is no less necessary, relevant and meaningful to our therapeutic aims as Child Psychotherapists. The unconscious, multi-directional interconnectedness of parent-child relationships is an important framework for our therapeutic work, which could be summarised into a process of reparation around rupture. For many of the families whose

children find their way to a Child Psychotherapist, painful, troubling life experiences have torn into the fabric of their lives and impaired the child's object relations as well as those of, and to the parents. I would like to bring this therapeutic process to our attention through a clinical illustration of work in a public sector child and adolescent mental health clinic with a boy whom we shall call Karim.

Clinical Account

Both the concrete and symbolic roles of parents in this treatment were pertinent to the therapeutic process, and ultimately, its gains. I had first met with Karim's mother Mrs T a few months prior to what we would later know to be the start of the Corona virus pandemic. We were joined by Ruth, the Clinical Psychologist from the Learning and Disabilities team who had referred Mr and Mrs T's five-year-old son to Child Psychotherapy. Mrs T and I had an unusual link, which she delighted in. We shared a native French tongue, in which she could express herself fluidly in our meeting, to speak to her son's turbulent history and the shared family dramas etched through his developmental narrative.

Karim is the sole child in the couple's care. Mrs T had become aware that a relative in her native village in North Africa was pregnant with a child conceived in a relationship not acceptable to the family. She had been unable to terminate the pregnancy and discussions began about a possible adoption. Karim's mother fled at the birth, so that he was left without nourishment or care. Mrs T's own parents rescued the child and brought him into their care for the first year of his life. Mr T was able to leave France to share in Karim's care with maternal grandparents in North Africa. There were early signs of developmental trauma in Karim, including head-banging, but otherwise he reached his developmental milestones. After this first year in North Africa, the adoptive family were reunited in France.

When Karim was two, his parents moved to England. He was experiencing some worrying health difficulties which required investigation. The adoptive couple wanted these to take place within the French medical system with which they felt at home. During a stay in hospital, there was a mishap, and Karim suffered a stroke. He was left paralysed down his right side, and suffers from fits, which continue to cause anxiety about ongoing neurological damage. He initially remained in hospital in France with his mother, separated from his

father at work in the UK, and continued to require hospital treatment on return to the UK. Some movement returned to his leg after lengthy procedures, but not his hand.

Introduction to Parents

These were parents who had fought to support their son's own fight for life in his earliest hours of abandonment and survival, in the immediate aftermath of his birth. The adoptive parental couple were committed in their ongoing fight for their child's needs. They dedicated their emotions, energies, and intelligence to advocating for and attempting to meet their son's needs, through access to relevant services, and making their own personal or professional compromises to focus on these.

Mother appeared driven by a mixture of anxiety and anger; this included a struggle with her own depression, despair and guilt, at her son's medical misfortune. She oscillated between fury at the medical authorities who had let them down, and awful feelings about her own perceived failings to keep her son safe. Father took a more pragmatic, resigned view of the tragedy. Parents adored and were exhausted by their adoptive son in unequal measure. They had had to adapt to communication made harder by Karim's post-stroke linguistic regression, exacting anxious preoccupations, and furious, erratic, emotional and physical outbursts, which sometimes left father in a position of physically restraining his son to avoid harm to himself or others. They also had to be watchful of his daily, periodic strokes, and to keep up with his medical appointments across both sides of the channel. The severe separation anxiety towards both parents was restrictive for them as a family, despite father's steadfast efforts to set boundaries.

Referral to Children's Mental Health Services

Presenting with these difficulties, Karim was referred to children's mental health services for social and cognitive assessments. Ruth, the Clinical Psychologist responsible for these, concluded that the medical complexities of Karim's case were obscuring the symptoms of severe trauma consequent on his terrible life experiences and repeated loss of home.

Parents were able to tolerate the hypothesis that their son was suffering from psychological impairments alongside medical illness. It seemed to speak to the image that

father was haunted by of his son's head-banging during his first year of life in North Africa. I wonder whether parents' openness to the hypothesis of developmental trauma allowed them some relief, that both the Psychologist, and myself, were taking an interest in their son's experiences that looked wider than his bodily, medical presentation. I believe that for mother, it was a hopeful miracle, within such repeated misfortune and pain, to find this particular clinical fit for her son. Here was a therapist with whom she could find common understanding as a woman with familial language, culture, and education, and an openness to thinking holistically about the family's painful journey. It was a step-by-step approach that also in part facilitated this tolerance. I presented my offer of help as a Psychoanalytic State of Mind Assessment. I described the assessment as a space in which we might begin to find out what it means to be Karim, to gain an insight into what it might be like for him inside, meaning some of his struggles, and how he sees himself and others in his world.

Psychoanalytic State of Mind Assessment

It was mother who attended introductory appointments and with whom I developed a relationship over the phone, ostensibly because of father's work commitments. I wonder whether Mother needed to scrutinise the woman who would be getting close to her son, and would be providing the prospect of therapeutic healing which she painfully knew was needed, in spite of her extreme dedication and love as a parent alongside her husband. This was especially sharp for a mother for whom such serial, inadvertent harm had come to her son, including from those who were intended to care for him.

This telephone relationship burgeoned and lengthened as the assessment was delayed under the unpredictable medical appointments which dictated family life, and the clinic guidance on suspending in-person clinical work during the initial waves of the Corona virus pandemic. The assessment, 6 sessions over 8 weeks to adapt to Karim's health needs, began well over a year after my introduction meeting with mother and Ruth. Mother had since taken up employment which brought father as the sole parental presence to the clinic. I first met with him alone, gathering his experience and perspective, adding a layer of new beginning, and thinking about how we could support Karim to participate in the assessment.

This brings us to the experiential challenge of working with the theoretical parent-child model outlined earlier. Finding a way to reach the child, and searching for creative, adaptive responses to the presenting difficulties of the child in need, is at the heart of our work as Child Psychotherapists. Yet it is exposing and uncomfortable, and more so when one intuits that the path to finding this child requires the parent to be physically rather than symbolically present in the room, as one tries to work in this way.

Karim, now aged 7, clung onto his father as we walked to the consulting room to begin his assessment, and buried himself into him, and under his chair, once in the room. We spent sessions with Karim in a foetus-like state, his strong, functioning arm hitting father hard as his moans and groans intensified with force. There were parallel tasks of attempting to hold a functioning exchange with father around what had been going on for them as a family, while he attempted to hold boundaries around his son's hitting out, and I tried to listen out to the unconscious communications underlying Karim's vocal emissions and physical contortions. I spoke aloud to these as the despairing cries of an infant for whom no-one is coming. A technical challenge of speaking Psychoanalytically to these unconscious communications, was father hearing them as descriptions of his son's behaviour and, with his own rising frustrations towards his son, directing sometimes concrete accusations of Karim behaving like a baby.

This awkward balancing of tasks, amid conscious and unconscious communications firing at different levels of the parent-child relationship, posed a challenge to the idea that this model was a helpful, therapeutic one for reaching Karim. A haphazard throw of a ball from Karim's hiding place in my direction, which by chance I caught, sparked our first link and eye contact, and even a mischievous smile from Karim. This contact instilled hope that there was potential for growth within the context of this Psychoanalytic model of observation and working with the unconscious and live parent-child relationship. Karim began to emerge from his hiding place, and hiding and being found became a significant communication which he would return to again, and again.

Intensive Psychotherapy

I observed a suitable fit in Psychoanalytic Psychotherapy for Karim and recommended intensive work of three times a week following on from the state of mind assessment. This began several months later with an intervening operation on Karim's leg. The intensity and complexity of the case, and ongoing medical and educational uncertainties, determined a decision for parents to have a separate allocated parent worker in Ruth, their first relational link to the mental health service. It was mostly father who brought Karim to his sessions, and mother made herself available as much as possible, including to attend the fortnightly parent sessions.

Clinical Vignette 1

To further explore some of the challenges of acknowledging the significance of the internal representations that children hold of their parents, and the need to work with these creatively according to the unique presenting needs of each child, I will introduce live material from Karim's first Psychotherapy session.

In setting up the work, Karim's father and I thought together about his separation anxiety and restricted mobility. We agreed that father would spend the session in the room opposite the Psychotherapy room. At our first session, I indicated this to Karim, and had a sense from the wordless understanding between father and son, that this had helpfully already been spoken about between them before arriving. It was this openness in both Karim's father and I to join up to attend to what we both knew so far of Karim's internal world, which I believe touched on a glimmer of benign potential in care and relationships within it, amidst the inadvertently cruel treatment that had punctuated much of his young life. The attention given to his internal world and the significant relational ties to his father, may have led him through the door to his first Psychotherapy session, as follows:

Letting go of the ball, Karim shot a glance at the closed door. I felt that he was going to leave, suddenly. Instead, he grabbed the ball of string and handed it to me, keeping hold of one end of it. His eyes were bright with excitement as he opened the door and kept pulling at the string, maintaining eye contact. I forgot that he wasn't using actual words, because I felt like I was receiving instructions, to untangle the string to keep making it longer.

He kept on putting the string as far as he could across the corridor, and in the room, and then rushing back. It seemed like he was worried that his father would spot him and tell him to stop and to go back to the Psychotherapy room. There was a mixture of fear and excitement. He would extend the string over to where his father was and return to me with sharp eye contact as I stood in the open door, tending the string for Karim to extract more from the tangled ball.

The manager for the service came along and asked if it was okay to go past. Another colleague froze at the sight of the string spread across the corridor floor, as if unsure what to do. Karim was stood in front of me, and I instructed him to let the lady go past. She thanked us and walked on. He quickly scurried back over. This time, I entered the room with him, to find that he was draping the string around his father's chair. Father was on the phone, explaining to his son in French that he was making phone calls to save time later. Karim was giggling with anxious, excited mischief. His eyes darted from me to his father, to the string, "Look behind you, Dad" he squealed in French.

As if mission accomplished, Karim left the door open to his father, and we returned to our Psychotherapy room. I closed our door behind us, the string trailed across the two rooms, holding my breath, anticipating that Karim would rush to open it. He showed no reaction to me doing this. Instead, he headed straight for the shelves, and brought over the toy doctor's set, as well as dragging the baby-doll from his box. I sat on the couch as he placed the items next to me, and with his eyes and head movements, showed me that he wanted me to open the doctor's box. Karim took a quick glance at the medical tools, before putting them to use. He first inspected the baby-doll's ears, then injected it hard in the stomach with the thermometer. He ran his fingers over the dent in the foam where the force of the thermometer had squashed it down. He proceeded with another implement. With every inspection, I felt my own body grimace under the impact of the harsh knocks to the doll's body and head. Karim suddenly threw the baby-doll hard against the wall. That was the end of that game.

This extract from Karim's first session highlights the technical challenges of working to attend to children's unconscious communications until they might reveal their content and meaning to us, holding in tandem the parent-child relationship as part of these

communications. Working in a busy clinic, there are practical challenges and considerations of a Psychotherapy session spilling out of the confines of the room into the corridor of public use for clinicians, and families, with service-led health and safety parameters. I was keenly aware of these in the session, while staying with Karim's purposeful need to forge a link between the unconscious sphere of the Psychotherapy room, which he had experienced during his state of mind assessment, and his father's whereabouts. The tangled string seemed to me to be a battered map which Karim needed to show me his route. For this boy who was lost and unmoored, it felt relevant to the task to venture towards understanding Karim's internal preoccupations to follow and perhaps eventually discover the meaning of this link.

There was perhaps an element of needing to connect up with his father as the boundary-setting parental figure. From this internal representation, Karim could draw courage in sourcing the internal representations of his own experiences, represented through the medical play with the baby-doll. The door to the Psychotherapy room shuts behind him, but he knows that the link is still concretely maintained. I interpret this as an intuitive understanding in Karim that for healing and development to take place, the internal representations of his parents, formed in part through lived trauma, needed to be brought to my attention. His communication to me as his therapist, was that this was a relevant part of himself to be worked with, explored and perhaps ultimately understood.

Karim needed help with bringing something together in himself; for the baby who had suffered alone, to be able to access and join up with a part of himself whom he also knew was cared for. This part of himself was in a relationship with internal versions of benign, loving parental figures. The baby-doll and the medical play appeared repeatedly in his sessions over many months, for this internal development from cruelty to care to take place. The physical distancing of Karim's parents into the waiting room or their separate parent-work space, translated into bringing them closer to view within the symbolic sphere of his sessions. Parental relationships, roles, and dynamics appeared within the constellation of hospitalisation family drama centred on the baby-doll.

Clinical Vignette 2

The intense separation anxiety from parents was a salient symptom of Karim's referral to Children's Mental Health Services. Karim needed help from his Psychotherapist to observe, delve into and explore the substance of this anxiety. Together, Karim and I needed to discover what the internal representations were which made this anxiety necessary to his emotional survival, as indicated in this enacted relational pattern to parents. The deepening dependency and intensity within the transference to his therapist was a useful insight into Karim's unconscious anxieties on the terrifying and catastrophic consequences of separation and being left alone.

The following extract takes place halfway through our work together, following a change in parent worker from Ruth, to Rachel:

Karim started making ghost noises. "There's a monster" he said, and left the Psychotherapy room. I found him in the room opposite, playing with a big bouncing ball which he knew wasn't allowed. We got locked into a game of him taking it, me putting it back, him running, me chasing after him. I stopped, noticing, in French, "Karim, we're being like cat and mouse, constantly running after each other, so that we're always together, never apart". I put the ball on top of the cupboard, out of reach. He tried to climb it, and gave me a mournful look as he realised that he couldn't reach it. He gave up, letting his body collapse onto the floor. His head near my shoes, he started cleaning them with his spit, insistent that I needed to keep them clear of germs. "You are ill" he declared. Pointing to the medical kit, and with my help, he put the stethoscope in his ears. He grinned at me, "You are better". I informed him that we needed to go back to our room, for the last few minutes of the session, before I brought him to see Mummy, Daddy and Rachel.

Karim threw himself on to the floor, pretending to die. I inspected him with the stethoscope. He started breathing heavily to indicate that he was alive, and turned to grin at me. Just as soon as he had come back to life, he collapsed again, in a deathly state. In these intervening bursts, I spoke to his worry about staying alive, in my mind, in the break, as if his life depends on this contact between us. "Time to go?" he asked. He continued dying and reviving until I announced the ending of today's session.

Karim's ghost noises bring to mind Selma Fraiberg et al.'s (1980) titular paper "Ghosts in the nursery". It is a paper which observes and describes how parents' preoccupations with their own traumatic internal representations, including those of being parented themselves, prevent them from being freed up to be lucid about, and respond to the needs of their child in the present moment. Karim presents as a child haunted by his own ghosts of catastrophes past. This sequence with his therapist reveals how he must use any means necessary to keep his internal relational parental objects interlocked with him. To risk separation from his parental object, is to risk the coming back to life of the ghosts of his infantile survival at birth and subsequent terrifying medical mishap. He was cut off from his parents, losing consciousness at the point of his stroke, and waking up to a lost connection of speech and physical capacity to reach out to them.

Being with Karim, as these internal representations take shape as a visible third before us, is where we find hope for therapeutic shifts in the child's internal world. We hope that the cries of the ghost will become quieter, to make room in this internal landscape for new sounds and shapes of relational possibilities. The playfulness in the symbolic play, the grin, the therapist who quickly heals to become well, all signal a burgeoning connection in an inside place to a life-affirming relational dependency. Karim can take in fresh breath, even in short bursts, in the freed-up space that comes from working through the internal representations of catastrophes past that have been choking him.

Parent Work Sessions

Parents were also working hard, both to support the continuity of Karim's Psychotherapy, and in their own separate work. They flooded their sessions with anxieties of the medical and educational dilemmas from their day-to-day life as a family. These present concerns stirred their unconscious, internal views of themselves in relation to their son. They brought their pain at past traumas, their ongoing effects in the present, their limitations as parents in how they could protect and advocate for their child's difficulties in the world. Also surfaced their grief and struggle to make sense of the loss of their well and able boy and fears for their son as he is now. Yet they were fortunate to have the capacity to project these internal cries and relational representations into their parent worker, and also that she could receive,

digest and contain these. At times there were unbearable feelings of helplessness, powerlessness, or fury and despair that nothing could be right for their boy. Partway through the Psychotherapy, parents had to bear the unwanted loss of their initial parent worker, Ruth, announcing her retirement. They were able to navigate this difficult transition with a careful, thoughtful handover, to sustain the life of their own work and their son's Psychotherapy.

I believe in part that the foundational work in the earliest points of contact with the family was crucial to this. The service had held steady, and honoured the treatment offer, despite the gaps in contact due to the Corona virus pandemic and medical delays. There was also a recognition of the unique realities of this family's life, and what would be needed to meet them where they were at, at the point of needing help, and throughout the life of the Psychotherapy, so that missed sessions were not punitively responded to with accusations of disengagement from the service, but were worked with. The family had a capacity to find and re-find contact with a benign and caring transferential object in the clinic, despite their tragic experience of hospital settings, and unplanned changes throughout Karim's Psychotherapy treatment.

Containing parents' anxieties into this space eased Karim's watchfulness and preoccupation with his parents' state of mind. He knew that they were being taken care of. This was significant for Karim, to feel that his parents were being held. He could then direct his mind and energies to his own intensive Psychoanalytic work on his internal representations. The separateness of these Psychoanalytic work-spaces and their lived benefits over time, created an opportunity for an experience of being apart as benign, developmental and even freeing. In this two-pronged parallel process, the internal representations and accompanying voices of parent and child were being heard and attended to, rather than being given information, education or behaviour management strategies. This challenging, but necessary work of emotional digestion and containment on behalf of the parent workers and Karim's therapist, created internal space for the whole family. They could experience some lighter, hopeful aspirations for their son and family life, amidst other heavier realities, and be more present to seeing each other as they were, with their limitations and life-affirming capacities.

The openness to the work of mourning in parents, Karim and their therapists, enabled the cries of the child whom they had been haunted by, to fade into the background of their internal worlds. Both Karim and his parents were now freer to see and know of the vivacious child who said goodbye and parted from his Psychotherapist.

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"Je Rêve de Vous" (I Dream About You)

Reflections on Verity Emanuel's *Ghosts Unheard and Shapes Unformed*

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I would like to begin my discussion with a feeling of deep humility and an awareness of how limited words can be in the presence of such powerful and moving clinical material. Before I share my thoughts and reflections, I would like to start by saying that it touched my heart and moved me profoundly Thank you, Verity, for granting me the privilege of witnessing such an intimate testimony. I have chosen to give a title to my discussion, although it may be somewhat unusual, but I hope that by the end it will reveal its full meaning.

I will divide my discussion into two parts. The first part includes several theoretical references that I would like to share, drawing from my training and experience as a psychoanalytic family therapist (and in particular from my work with families who have adopted children). The second part contains reflections on the clinical material that was presented.

I would also like to thank Verity for offering us this opportunity to understand the specific nature of an intervention within an institutional setting and the differences that exist between this framework and private practice. The institution allows us to understand the role of a multi- or interdisciplinary team, how a step-by-step intervention works, how a therapeutic indication is addressed, as well as the limits and obstacles of such a psychoanalytic intervention.

Theoretical Considerations

When working with the parental couple or with a child — always keeping in mind the representation of the parents — it can be very helpful to draw on some of the theoretical conceptualizations developed by key authors in the field of family psychoanalysis. While reading the beautiful material presented by Verity, I was reminded of the contributions of E. Pichon-Rivière, Pierra Aulagnier, and André Ruffiot.

I will begin with André Ruffiot's (1981) well-known phrase, «on est tissu avant d'être issu » — "we are woven before we are born" — which clearly illustrates the central place that the family and previous generations hold in the development of a child.

According to Pichon-Rivière (2004), the family as a group is structured through unconscious links. These unconscious representations take shape in the family's habits and beliefs, which correspond to the original group of belonging. In other words, in order to truly listen to a family, one must understand its beliefs and habits.

Enrique Pichon-Rivière (2004) tells us that the subject suffers from insecurity, from love and from hate — from burning desire and from lack: from love, through a need that was not sufficiently satisfied, and from hate, because the group of origin (the family group) does not allow the subject to form a distinct identity. This is a group where there is little differentiation: "One does not know who is who". This is a situation we often encounter in the families who come to consult us.

The family is a group characterized by:

– links of alliance and filiation, as well as by the prohibitions that govern them (prohibitions of incest and murder);

– the way it organizes relationships among its members and between generations, according to its history, culture, and myths;

– the way it is structured by a double task, both manifest and latent.

The choice of the parents' love objects — their mutual investments and identifications — determines for each of them the choice of an Other who is at once familiar and foreign, similar and different. But an unconscious alliance between them is necessary for the link to be constituted, one that hides or sets aside whatever could threaten or destroy

the establishment or permanence of this link. This is what Kaës (1993a) calls a "negative pact." It is defined as an "unconscious agreement on the unconscious, imposed or concluded by those who maintain the link." This pact is established, in principle, to protect the family links. There are things that must not be said in a family. For example, children may sometimes hide things in order to create their own private inner world.

In the alliance link, which constitutes the family tie, unconscious alliances, pacts, and contracts (in particular the negative pact and the narcissistic contract) are necessary for the construction of links. They protect the group from the disorganizing effects of certain transmitted elements, thus creating "containers of negatives."

When a child is born, a family mandate is transmitted to them through the narcissistic contract (Aulagnier, 1975). Through this contract, the parents inscribe the child within the succession of generations and within the family group. They assign to the child a predetermined place and role, in connection with the discourses that preceded them, recognizing and investing in them as heir. Entrusted with the mission of ensuring the continuity and togetherness of the group, the child bears a share of what is sealed within the alliance's negative pact that holds the family together. It is in this position, and thanks to this investment, that the child's singular subjectivity is founded.

The child must accept and sign this contract. The problem arises when the child is unable to assume this place — either because they reject the mandate, or because a disability prevents them from doing so.

This is why André Ruffiot (1981) brought to light a specific modality of therapeutic work with families: dream-holding. This refers to "oneiric" responses of one family member to another. This work allows the filling in of gaps in the fantasied life through the recreation of the "family novel," which restores both continuity and psychic differentiation for each member of the family. In this way, the revival of holding situations takes place during family therapy, within the transformative process of parenthood.

This takes into account the formation of the group's psychic reality and the processes of inter-fantasies movements among family members. Ruffiot thus recognizes and names a specific entity: the family psyche, which presupposes a primary state of non-integration

between psyche and soma (a pure, unintegrated psyche) — the most primitive form of unconscious communication within the family.

This leads to the work of historicization — in an après-coup process and through the working-through of their experience. This allows the child to restructure elements of their history, giving them access to a more complex context, to a new family novel, a renewed memory of intergenerational transmission.

Clinical Reflections

Through the clinical material, Verity offers us a true kaleidoscope in which the different configurations of external relationships and inner object relations are reflected in turn: father–son, mother–father, therapist–Karim, mother–son, therapist–institution, and so on. But what if we were to look at the family as a whole for a few moments?

From conception, the child is inscribed in the network of family myths, unconscious pacts, and transgenerational transmissions that shape his place in the world.

In Karim's case, adoption added an additional layer of psychic complexity: he entered a family in which the narcissistic contract had to be rewritten in order to integrate a child who was not biologically theirs. The adoptive parents' psychic task was to create a space where this child could be invested as heir, without being crushed by a mandate that did not belong to him. When catastrophic events — abandonment at birth, medical trauma, paralysis — tore through this contract, they produced a narcissistic wound, threatening the very possibility of a new (a)filiation.

In adoptive families, the mourning of origins is often a delicate and sometimes impossible task. The child carries within him a "crypt" (Abraham & Torok, 1978) of unspoken history: the lost biological parents, the primal abandonment. In Karim's case, this crypt is further sealed by the stroke and its aftermath, as if the body itself carries the traces of the original catastrophe. The play with the baby doll and the medical kit becomes a theatre where this unspeakable drama can be enacted, destroyed, and eventually re-symbolized.

Fusional links, as described in family psychoanalytic theory, appear here as defensive formations against the terror of catastrophic abandonment. Karim's intense separation anxiety (confused with death anxiety), his clinging and hiding, are not simply regressive

symptoms but attempts to keep the psychic group from disintegrating. The father's bodily presence becomes both a shield and a potential prison. The therapist's challenge is to offer a third position — neither intruding nor abandoning — so that differentiation can gradually emerge.

The role of illness as a psychic expression is especially striking. The stroke, the seizures, the neurological fragility — these are not only medical events but signifiers in a complex psychic economy. They provide a "scene" (Laplanche) where the family's anxieties about loss, guilt, and survival can be staged. Karim's repeated dying-and-reviving games make this dimension explicit: he tests whether the therapist's mind can survive his psychic death, whether he himself can be reborn.

Therefore, there is a form of violence that attacks the very process of symbolization and of becoming a subject. Karim's early history is punctuated by ruptures — maternal flight, medical crisis, repeated separations — each of which reactivates this fundamental violence, threatening to fragment the identity of both the child and his parents. Another form of this violence takes the shape of the parents' fantasy of destroying the child through their inability to heal or repair the original trauma. This fantasy can also be evoked by the therapist's countertransference in the face of repeated attempts to test the container and the violence felt by the witness witnessing that violence.

The therapeutic setting must therefore function as a "double skin", containing not only the child's projections but also the parental feelings of guilt, rage, and despair. Verity's clinical vignettes show us this holding in action: the therapist enduring Karim's blows, the father's frustration, and the ghosts of medical trauma. The string stretched across the corridor and room becomes a symbolic skin, a fragile yet vital link connecting disparate psychic spaces.

I was particularly struck by the early alliance between the mother and the therapist, rooted in a shared native language. This maternal tongue functions as a first container, a recovery of primary holding. It gives symbolic space to Karim's story, acknowledging his early abandonment and the traumatic fractures that mark his history.

An important contribution of Verity's paper is its reminder of the value of institutional containment. The multidisciplinary team provides a containing envelope that mirrors the family's own psychic envelope.

I would like to conclude this discussion with a musical reference. There is a song called Kwibuka, a very powerful word meaning "to remember," written by Gaël Faye (2020)— writer and singer, who also authored the novel Jacaranda (2024) denouncing the genocide in Rwanda.

Je rêve de vous, chanson d'un soir d'ivoire
Je rêve de vous, mes mots sont dérisoires
Je rêve de vous quand l'Histoire nous égare
Je rêve debout au jardin des mémoires
Et vu que je renais déjà de nos abysses
Je fais de nos sourires d'éternelles cicatrices.

(I dream of you, a song of ivory night
I dream of you, my words are only slight
I dream of you when History leads us astray
I dream awake in the garden of memories
And since I am already reborn from our abysses
I turn our smiles into eternal scars.)

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Working With Parents in Child and Adolescent Psychotherapy – a Challenge

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Thank you for this extremely interesting and touching account of the psychotherapeutic work with Karim and his parents. I was deeply moved to witness what the work with this multiply traumatized child and his troubled parents looked like, and how it ultimately led to a positive outcome.

Verity Emanuel clearly demonstrated how important working with parents is for achieving positive results in helping children cope with severe traumatic life and developmental circumstances. She also shared with us the unique features and difficulties of this work.

Let me now make a few further comments on the topic of involving parents in psychotherapeutic work with children and adolescents, based on my experience as a practicing child and adolescent psychotherapist and director of a training institute in Germany.

A little girl suddenly starts screaming at a family celebration celebrating her first day of school and can hardly be calmed down. Another child begins to stutter at the age of five and develops social difficulties. Another becomes disruptive in kindergarten and starts wetting herself. Yet another suddenly and stubbornly refuses to go to school. This list could

go on. You are all familiar with the behavioural and developmental disorders that children come to us for.

The worried and insecure parents, torn between the responsibility for their child and the shameful feeling of having somehow failed, seek advice and help in child psychotherapy, usually without having the slightest idea of how deeply the psychological suffering of their children is interwoven with the history of the entire family over several generations.

Psychotherapeutic work with children and adolescents is generally both challenging and rewarding. Children and adolescents are in dynamic phases of development. Their psychological challenges rarely affect them alone, but almost always interact with their family environment.

Working with parents, as the most important caregivers, is a key parameter in psychotherapeutic work with children and adolescents and represents an often-underestimated challenge. The working alliance with these caregivers is a necessary prerequisite for the success of treatment and thus for the child's development.

In the treatment of adolescents, too, talking with parents at the beginning or in crisis situations during therapy can contribute to the progress of treatment or prevent failure. For example, if conflicts of loyalty or guilt, fear of shame, or unconscious transgenerational issues are blocking development, parent-psychotherapist meetings or family meetings with adolescents and their parents can remove blockages and get the treatment process back on track.

Based on the assumption that symptoms are the result of conscious or unconscious processes that develop in interaction with primary caregivers, organize themselves meaningfully, and are expressions of internal and interpersonal problems, the conclusion is that healing, at least in children, is neither possible nor sufficient without these caregivers. Furthermore, it can be assumed that the child's problems not only draw attention to internal conflicts but also to problems within the family.

Many therapists face the challenge of adequately involving parents in the therapeutic process. In doing so, they must juggle the child's needs, the parents' concerns, and the therapeutic goals. This requires sensitivity, clear communication, and a stable therapeutic

approach. Supportive parent work involves the ability to build trust, overcome barriers and resistance, integrate perspectives, and formulate shared goals, often under challenging conditions.

When parents themselves are physically or mentally ill, this can have a significant impact on the child—be it through emotional distress, insecure attachment, or the assumption of roles that are not age-appropriate. Parents from different cultural backgrounds, separated parents, highly conflictual parent-child relationships, or blended families often pose difficult challenges in child psychotherapy and require additional, in-depth knowledge.

While working with parents is a complex undertaking in any child psychotherapy, working with mentally ill parents can be extremely challenging. Mentally ill parents are generally even more sensitive to their parental role. They find themselves caught in a tension between their own demands, the expected criticism from outside, feelings of shame and guilt, and fear of failure. This makes it difficult to develop an unbiased relationship with their children. In the psychotherapeutic relationship, this can manifest itself in a fluctuation between idealization and devaluation. But real separations due to hospital stays or insecurities caused by illness-related emotional withdrawal versus irritable-aggressive behaviour can also place a massive strain on the parent-child relationship and hamper the child's development.

In Germany, training as an analytical child and adolescent psychotherapist is fundamentally based on the assumption that working with parents represents the true challenge of therapeutic work, one that can be decisive for the success or failure of the entire psychotherapeutic process. Therefore, German psychotherapy guidelines stipulate mandatory work with parents at a ratio of 1:4.

I would like to discuss the following questions and topics with you, among others:

1. Why is our work not possible without parents, and whether and how treatment dropouts in psychotherapy with children are often due to insufficient parental involvement?

2. Diagnosis of the parent-child relationship: Since the relationship between parents and child is at the heart of parental work, the goal is to clarify how well the parents can fulfil their parental functions. How can this be achieved? What spectrum of theoretical knowledge and methodological concepts is necessary to psychodynamically interpret the interrelationships between the child's disorder and disorders of the parents or the family system, and to derive treatment goals and the appropriate setting from this?
3. The framework agreement and clarification of the setting: How do you determine which setting is best? Parent work alone without child therapy; parent work and individual therapy for the child with the same therapist; parent work and individual therapy for the child with a different therapist; parent work in parent groups; family therapy instead of parent work with a different therapist. Is an initial, detailed assessment phase necessary until a sustainable working relationship with the parents is established?
4. Importance of the therapeutic stance: How can the therapist, as the guardian of the setting, best ensure adherence to the framework so that, through the therapist's efforts to foster empathy, in a supportive relationship, and through the security of the framework, the parents experience, as an example, a stance that they themselves would prefer in their interactions with their child?
5. Are there relevant differences in parent work regarding the design and attitude of therapists in clinical and outpatient settings?

Thanks for your attention.

Institutional Section

EFPP Regulation Working Group – Progress Report

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EFPP Regulation Working Group

Chair: Cristina Călărășanu

Duration: 2 years (November 2024 – November 2026)

Members: Spain, Germany, Bulgaria, Belgium, France, Italy, Turkey, Romania, Netherlands, Sweden, Kazakhstan, Portugal, Slovenia

Meetings: Every two months, 2 hours each

Period covered: November 2024 – September 2025

Introduction

The Regulation Working Group was created following the EFPP Delegates Online Meeting in March 2024, where members expressed deep concern and interest in the regulation of psychoanalytic psychotherapy across Europe.

Each country faces unique challenges, yet there is a shared sense of urgency to clarify professional recognition, ethical standards, and institutional positioning within the wider European context.

The EFPP Board established this group to explore these regulatory frameworks, better understand the political and institutional contexts, and prepare an official EFPP document that can guide national associations in their dialogue with local authorities.

The group's work aims to strengthen EFPP's collective voice and safeguard the future of psychoanalytic psychotherapy across Europe's changing professional landscape.

Structure and Goals

The group is coordinated by Cristina Călărășanu (Romania) and brings together representatives from 13 countries. Meetings are held every two months online. Its initial plan covers two years, with the first phase dedicated to country presentations and exchanges of national experiences. Later, the group will produce an EFPP statement or paper on regulation and may collaborate with the Training Working Group and respond to WHO initiatives.

Key questions guiding the discussions include:

- Who regulates the profession of psychotherapist?
- What are the regulations in public and private sectors?
- What is the position of psychoanalytic psychotherapy within the wider field?
- How are confidentiality and ethics handled?
- What is the relationship between the state, insurance systems, and psychotherapists?

Summary of Meetings and Progress

1st Meeting: November 5, 2024

The group was officially launched. Members shared an overview of their national contexts, noting large variations in regulation and training structures.

Three key focal points emerged:

1. Who is the regulator? (state, professional colleges, or insurance bodies)
2. Who decides ethically?
3. Who provides training?

It was agreed that each meeting would feature 3 country presentations answering the guiding questions, and that meetings would occur every two months.

2nd Meeting: January 29, 2025

Presentations: Germany, Belgium, Romania.

Main insights:

- Germany: Highly structured regulation; psychotherapy legally defined and supervised by the state. Distinction between psychological and medical psychotherapists; complex licensing and revalidation (250 credits per 5 years).
- Belgium: Psychotherapy considered an "act" under the Health Care Law rather than a profession; strong insurance influence; confidentiality concerns linked to the new Electronic Patient File.

The meeting showed contrasting systems — from overregulation (Germany) to fragmented frameworks (Belgium). It was decided to limit to two presentations per meeting and plan further sessions for Romania, France, and Poland.

3rd Meeting: April 29, 2025

Presentation: Romania (Cristina Călărășanu).

Romanian psychotherapy regulation established in 2004 under the College of Psychologists.

Key issues:

- The College holds strong control over accreditation and ethics.
- Ongoing debate about a new law that could centralize power and reduce autonomy of psychologists.
- Multiple psychotherapy schools (including psychoanalytic) coexist, but university teaching is dominated by CBT.
- Majority of practitioners work in private practice due to limited public funding and bureaucracy.

Discussions emphasized the political dimension of regulation and the need for professional involvement in shaping laws.

4th Meeting: June 24, 2025

Presentation: Netherlands (Keren Amouyal).

- Psychotherapy is a protected profession under law since 1993.

- Requires a Master's in Psychology plus a 2-year postgraduate program.
- Registration under the BIG Register; revalidation every 5 years.
- CBT dominates training and recognition; psychoanalytic psychotherapy less visible.
- Insurance system determines much of clinical practice, with strict documentation and data-sharing rules.

Discussions explored the impact of regulation on clinical freedom and confidentiality, drawing parallels with Belgium and Germany.

The group agreed to continue with presentations from France and to later review the WHO Psychological Interventions Manual.

5th Meeting: September 30, 2025

Presentation by Cristina Călărășanu and Maria Eugenia Cid on the WHO Psychological Interventions Manual.

The discussion focused on evaluating the place of psychoanalytic psychotherapy within the WHO manual, the types of interventions described, and the training approaches proposed. One of the main conclusions was that the manual appears to be more educational or business-oriented rather than clinically grounded.

Although it addresses the management of psychological interventions in underprivileged areas, the group noted that its approach seems superficial, aiming more at cost reduction than at ensuring adequate and ethically sound psychological care.

A proposal emerged to develop and present an EFPP version of such a manual, highlighting the advantages and depth of psychoanalytic psychotherapy as a distinct and essential approach within mental health care.

Emerging Themes

Across the meetings, several recurring themes have been identified:

- Growing institutional and insurance control over psychotherapy practice.
- Unequal status of psychoanalytic psychotherapy compared to CBT and integrative models.

- Tension between regulation and professional autonomy, particularly regarding patient confidentiality and digital records.
- Need for EFPP coordination to articulate a unified European position.
- Political awareness: psychoanalytic organizations must engage in policy discussions to maintain visibility and influence.

Next Steps

Upcoming presentation on France and Portugal

All the presentations are published in the EFPP e-journal.

Conclusion

The first year of the Regulation Working Group has been productive, establishing a clear structure and collecting valuable comparative insights into European regulatory frameworks. Although differences between countries remain significant, a shared need has emerged for ethical coherence, political presence, and collective advocacy within EFPP.

The group will continue its work toward developing an official EFPP statement to support national associations in navigating regulatory challenges.

Regulation Regarding the Title of Psychotherapist in France

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The Legal Framework

Until August 2004, there was no regulation concerning the title of Psychotherapist.

Law 2004-806 of 9 August 2004 on public health policy

Article 52 states the use of the title of psychotherapist is enshrined in law.

It is reserved for professionals registered in the national register of psychotherapists.

Registration is recorded on a list drawn up by the representative of the State in the department of their professional residence. This list mentions the training courses taken by the professional.

Registration on the list is *a right* for holders of a doctorate in medicine, persons authorized to use the title of psychologist, and psychoanalysts regularly registered in the directories of their associations.

This first article of the law regulating the title of psychotherapist stems from the government's desire to combat abuse and sectarian aberrations in the country. It was therefore not drafted with the aim of developing, regulating, or protecting the profession of psychotherapist as such, but rather to prevent abuse and aberrations.

Decree of 8 June 2010 on training in clinical psychopathology leading to the title of psychotherapist: This government decree clarifies the 2004 law on the use of the title of psychotherapist.

The decree specifies:

"*Training leading to the title of 'psychotherapist' includes:*

– a minimum of 400 hours of theoretical training in clinical psychopathology

– a practical internship lasting at least 5 months."

The theoretical training required is divided into 4 modules of 100 hours each; each module allows students to acquire or validate knowledge relating to:

1. psychological development, functioning and processes
2. criteria for distinguishing major psychiatric disorders
3. theories relating to psychopathology
4. the main approaches used in psychotherapy: four approaches have been selected: cognitive; psycho-educational; CBT; EMDR.

The course may focus more specifically on one of the theories, devoting up to 75% of teaching time to it, with the remaining 25% used to present the other theories.

It is clearly stated that *this academic training cannot replace specific training and teaching methods for psychotherapy.*

The five-month internship enables trainees to:

- put into practice the theoretical training in clinical psychopathology they have received, with a view to gradually becoming autonomous.
- understand the place and role of psychotherapy in the care and rehabilitation process.
- put this learning into practice while supervising several patients.

Regarding the training in clinical psychopathology leading to the title of psychotherapist, six professional categories are listed:

Type of exemption	For whom?	What additional training?
Full	Psychiatrists	None
Full	Clinical Psychologists who have completed 500 hours of internship in a health, social, medico-social facility (ESSMS)	None
Partial	Psychologists who cannot justify 500 hours of practical training in a (ESSMS)	2 months of internship in a ESSMS
Partial	Non psychiatrist doctor	1 module (100h) of psychopathology 2 months of internship in a ESSMS
Partial	Psychoanalyst registered in a register of a psychoanalysis society	2 modules (200h) of psychopathology 2 months of internship in a ESSMS
None	Psychoanalysts who are not registered in a society and any other profession	4 modules (400h) of psychopathology 5 months of internship in a ESSMS

In summary, the law aims to protect the title of *Psychotherapist* by reserving it for qualified and trained professionals, notably psychologists, doctors, and psychoanalysts.

The decree has two harmful effects:

- The Regional Health Authorities (ARS) – government decision-making bodies – will tend to make the training in psychopathology (and its approach to it) the main requirement for validating the title of psychotherapist.

- Some of the professionals in the 6th category – non-doctors and non-psychologists – give themselves a new title, 'psycho-practitioner', thus circumventing the basic requirement of training in psychopathology.

In 2022, the 'Mon Soutien Psy' scheme was announced by the President of the Republic following the Mental Health Conference in 2021.

Improving access to mental health care has been a major public health issue since the Covid-19 pandemic.

The scheme aims to improve access to psychological support from the age of 3 for the urban population. It is aimed at people with mild to moderate anxiety or depression, tobacco, alcohol and/or cannabis misuse, or eating disorders that do not meet the criteria for severity.

In 2022, when it was launched, the scheme consisted of an assessment interview and seven sessions conducted by a psychologist approved by the French national health insurance system, following referral by a doctor, midwife or health professional from the school health services.

In 2024, it underwent several changes:

- The requirement for prior referral by a doctor, midwife or school health professional for psychological follow-up sessions to be covered by the Health Insurance Fund were removed.
- Patients would be free to choose the registered psychologist they wished to see.
- Communication between the psychologist and the doctor would only take place during the assessment interview and the last session, with the patient's consent.
- The number of sessions covered was increased from 8 to 12 per year.

Furthermore, the Minister of Health specifies in the Official Journal of 12 June 2025 that:

"The scheme is not open to 'psychotherapists', even those who have been authorized by the ARS (the government body responsible for authorizations).
Nevertheless, discussions on training for the profession have been initiated and the scheme may be expanded in the longer term by adding a "second component" dedicated to more severe disorders, i.e. psychotherapy."

C. Amendment 159

A proposal by four senators to stop reimbursing psychoanalytic treatments from January 1, 2026, was discussed and adopted in a Senate committee, to be debated in plenary session. It triggered mobilization within the community of the healthcare professionals (petition signed by over 100000 professionals):

"AMENDMENT moved by Ms. GUIDEZ and Ms. VERMEILLET, Mr. CANÉVET and Ms. JACQUEMET (plus two other senators who have since been added....)

ADDITIONAL ARTICLE AFTER ARTICLE 18 (DELETED)

After Article 18

Insert an additional article reading:

I. – As of January 1, 2026, care, acts and benefits based on psychoanalysis or based on psychoanalytic theoretical foundations no longer give right to reimbursement or financial participation by the health insurance.

II. – A decree in Council of State determines the modalities of application of this article.

Object

This amendment aims to ensure scientific consistency and efficiency of health insurance expenditure.

Psychoanalytically based care, especially when applied to neurodevelopmental disorders, anxiety or depressive disorders and chronic psychiatric conditions, currently has no scientific validation or positive evaluation of the medical service provided by the High Authority of Health. Several public reports have highlighted the lack of evidence of effectiveness and the inadequate, or even counterproductive, nature of these approaches, which are to be differentiated from psychotherapies.

In a constrained budgetary context, it is legitimate for national solidarity to focus its efforts on care whose effectiveness is demonstrated and evaluated. This amendment does not call into question the freedom of choice of patients or the freedom of practice of professionals. It simply ends the public funding of the practice, regardless of the funding mechanisms: My Psychological Support, medical-psychological centers, etc.

By refocusing health insurance spending on care with a proven medical benefit, the aim is to promote the dissemination of therapeutic practices recommended by the High Authority of Health, including behavioral, educational and psychosocial rehabilitation approaches."

The following are the Senate's conclusions regarding this matter, after debating:

"The main arguments that led to the rejection of the amendment aimed to defend therapeutic pluralism and the professional autonomy of healthcare providers.

1. *Defense of a Plurality of Approaches:*

Freedom of Care and Patient Choice: The central argument was that health insurance must guarantee a plurality of approaches and leave the choice of methods to healthcare professionals and their patients, based on clinical observation (the observation of symptoms) and the individual's needs.

Opposition to "State Psychotherapy": Many unions (such as the Union Syndicale de la Psychiatrie and the Syndicat national des psychologues) denounced an attempt to create "state psychotherapy" that would impose a single doctrine (in this case, cognitive-behavioral therapies or other brief therapies) while excluding other recognized approaches.

2. *Questioning the Relevance of Delisting from Reimbursement*

Confusion of Procedures: The rejection was based on the argument was that the amendment confused "acts and services claiming to be psychoanalytic" with consultations by psychiatrists and psychologists, many of whom are registered and contracted professionals who use a range of methods in their practice, including elements of psychoanalytic inspiration. The removal of psychoanalysis from the list of reimbursed services would have made it impossible to reimburse a large number of consultations.

Problem of Definition: It was difficult to define precisely and legally what falls exclusively under "psychoanalysis" in the daily clinical practice of a reimbursed psychiatrist.

3. *Criticism of the Exclusion of Professionals*

Lack of Consultation with Professional Organizations: One point raised by opponents was that the amendment, which had been adopted in the Senate committee before being debated in plenary session, had been tabled without prior consultation with the main organizations and unions of psychiatrists and psychologists, which was deemed unacceptable for a measure of such scope.

In summary, the Senate largely considered that the amendment represented excessive interference in clinical practice and therapeutic choice, and that it undermined the necessary plurality of mental health care".

Regulations of Psychotherapy

The Netherlands

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The regulation of the psychotherapist profession in the Netherlands:

- *Who*: Psychology graduates (MA), Educational psychologists ('Orthopedagogen') (MA), Medicine graduates like psychiatrists. Most psychotherapists in the Netherlands first complete a two year post master program of GZ psychologist before continuing to psychotherapy specialization.
- *Legal Framework:* Individual Health Care Professions Act (BIG Act) (start regulation in 1986 and official Act BIG since 1993.)
- *Regulatory Authority*: Ministry of Health, Welfare and Sport (VWS), BIG register
- *Protected Title:* "Psychotherapist" (only for those registered in the BIG register)
- *Education Requirements:* Master's degree in relevant field (e.g., psychology, medicine, mental health sciences) and Accredited postgraduate psychotherapy training program
- *Registration Process:* 1. Application to BIG register after completing education and training. 2. Assessment of foreign diplomas for equivalence
- *Legal Basis for Practice*: Practice only allowed after BIG registration; using the title without registration is illegal
- *Ethics and Conduct:* Three organizations responsible and monitor this: Code of Ethics by Dutch Association for Psychotherapy (NVP), Act on Medical Treatment Agreement (Wgbo) and Act on Quality, Complaints and Disputes Care (Wkkgz)

- *Professional Supervision:* Supervision during postgraduate training (150 hours), ongoing supervision for some specialties or early career professionals ('werkbegeleiding')
- *Re-Registration:* Periodic re-registration required (every 5 years). It includes sufficient work experience (minimum 16 hours per week), demonstration of continued professional development and adherence to standards.

The psychotherapy training (BIG) is not related to a certain method of therapy. Usually there is an integrated vision of different methods, though CBT tries to have most influence on the program.

What are the regulations in the public sector?

When provided by a qualified professional such as a GZ-psychologist, psychotherapist, clinical psychologist or psychiatrist, treatment is generally covered by public health insurance, provided certain regulations and procedures are followed.

Requirement/Step

- *Health insurance:* Mandatory, must be Dutch public insurance
- *Referral:* Required from GP (huisarts)
- *Types of care:* BGGZ (short-term), SGGZ (long-term/complex)
- *Provider*: Must be contracted by insurer (without contract and in the case of correct professional registration there will be a coverage of 50%-80%)
- *Deductible:* Compulsory (€385 in 2025), optional voluntary deductible
- *Professional registration:* BIG-registered (psychotherapist, GZ-psychologist, psychiatrist)
- *Billing:* According to national "zorgprestatiemodel" (problematic issues: 1. some information concerning the treatment must be stated or patient can sign a "privacy verklaring" not permitting therapist to report information to other parties. 2. bills must be sent directly to the insurance company through a digital platform).

This applies in the same way to private practices and mental health institutes or clinics.

Alternative Therapies:

Non-BIG-registered providers (such as some alternative therapists) are generally not covered by public health insurance, though some insurers may offer partial reimbursement for certain modalities.

Children and Adolescents:

For those under 18, mental healthcare is arranged via youth mental health services (jeugd-GGZ) and that is through the local municipalities, also requiring a referral.

In summary, public health insurance covers psychotherapy in the Netherlands if you have a referral, use a contracted, BIG-registered provider, and meet the deductible requirements. There are also requirements regarding the quality of the treatment I will address that later on.

Some people who have treatment in private practice, choose to self-finance the treatment to avoid that information about their situation will end up at the insurance companies. All psychotherapists in a private practice offer this option. This is, of course, not possible when being treated by the mental health institute or clinic.

How big is the group of mental health professionals?[5]

Profession	Number Registered (June 2025)
Basic Psychologists	~1,100 (probably more without registration)
GZ-psychologists	20,528
Psychotherapists	5,611
Clinical Psychologists	not specified
Psychiatrists	8,068
total	35,307 (not including clinical psychologists and exact number of Basic Psychologists.

The setting of psychotherapy (exact numbers are not known)

[5] Sources: BIG-register (June 2025), Zorgkaart Nederland (2025)

Outpatient: clinics, private practices, GGZ-institutions, e-health are very widespread. This group carry most of the work.

Inpatient: psychiatric hospitals, mental health institutions, hospital wards are much less widespread, specialized.

How does the mental health registration work and where is the psychoanalytic psychotherapist in the scale?

Master in (clinical) Psychology (3 years of BA and 1.5/2 years MA)

These are the "Basic Psychologists". They can treat patients under the responsibility of a BIG registered colleague. They mostly work in the mental health institutions as an affordable workforce.

GZ psychologist (BIG): 'Generalist'

The first post-doctoral BIG registration to become GZ psychologists contains almost entirely of a CBT training. The program is a full-time program of 2 years where only MA graduated are permitted (1x week 6 hours theory, 4 days work experience, 125 hours supervision, specializing in diagnosis and therapy).

Psychotherapist or Clinical psychologist (BIG): 'Specialist'

This is the second post-doctoral BIG registration both are 4 years part time studies (1x2 weeks 6 hours theory, at least 1200 working hours spread over the 4 years, personal therapy, at least 400 hours under supervision and 125 supervision hours).

The difference is in the focus. The focus of psychotherapy education is on complex psychotherapeutic treatment (individual, group, systemic) and the focus of clinical psychology treatment is on specialist diagnostics, treatment, research, and leadership in mental health care.

Another difference is that they are valued differently according to the BIG law (clinical psychologist is a specialist and psychotherapist is not).

Psychoanalytic psychotherapist: 'Super specialist'

Candidates are graduated psychiatrists, clinical psychologist and psychotherapists. Our training is on top of the at least 4 years of psychotherapy training they had before (and the GZ before). When the candidates start, they already had experience with a personal psychotherapy, supervision and work experience. The NVPP training program is a 4 year weekly training (450 hours), personal psychoanalytic psychotherapy of psychoanalysis (at least twice a week), supervision over at least 500 sessions (at least one supervision over a therapy lasting more than 2 years with a frequency of at least twice a week)

Psychiatrist

Able to follow the psychoanalytic psychotherapist education. In the specialization to become a psychiatrist they had comparable training as psychotherapist and clinical psychologists.
Other forms of psychotherapy like couples and family (systeemtherapie), group therapy have an additional training for GZ psychologists, psychotherapist, clinical psychologists and psychiatrist.

Child and adolescent have their own variation of BIG training where the accent lies on working with children and adolescents.

Some facts about psychological treatments in the Netherlands

CBT is the predominant form of therapy in the Netherlands (more than 40%)

In 2024: CBT 10000 members, Schema therapy 2503, EMDR 7000. they are organized together and have a total of almost 20000 members (some registrations are double)

How did it happen?

- Universities put accent on CBT as an evidenced based therapy
- Only very few psychoanalytic oriented university lecturers are employed
- Heads of departments of mental health institutions and clinics are CBT. Almost all the therapies in the institutions and clinics relay on these methods
- First post-doctoral BIG registration (GZ psychologist) contains almost entirely of a CBT training.

- Guidelines dictate to first treat with CBT before moving to another, more intensive form of therapy ('Stepped Care').

Psychoanalytic psychotherapy is practiced but have a small share of the offed therapies (10% – 15 %): It is respected and available, especially for complex or long-term cases.

Therapy Type	Estimated Prevalence/Trend	Notes
Cognitive-Behavioral Therapy (CBT	High (likely >40%)	Most widely used; preferred for depression, anxiety, and many common disorders
Psychoanalytic/Psychodynamic	Moderate/Low (approx. 10-15%)	Still respected, especially for complex or long-term cases, but minority overall
Online Therapy/Telehealth	Rapidly increasing (est. 20-30%)	Growing due to accessibility and digital infrastructure
Integrative/Complementary (e.g., mindfulness, art therapy)	Moderate (varies by setting)	Includes trauma-focused, family, and group therapies
Other (e.g., EMDR, systemic, group, family therapy)	Moderate (varies by setting)	Includes trauma-focused, family, and group therapies
Medication Management	High (often combined with therapy)	Common for moderate to severe cases, especially in psychiatric care

Payment by insurance

- All psychology treatments applied by a BIG registered professional or being supervised by one are paid by the insurance company.
    - Contract = full payment
    - No contract = partial payment depending on the insurance polis (50% - 80%).

- Insurance companies offer a percentage of the advise rate by the NZA when offer a contract and exploit in that way the power they have within the system.
- There is a guideline ('zorgstandaard') based on the diagnosis and professionals are expected to follow the guideline stated there.
- GZ psychologists are 'generalist' and suppose to treat short and effective according to a (CBT) protocol. They generally use a declaration system made for short term, complaint-oriented, psychological help. In the past they could declare up to 12 sessions per year but two years the system changed and there is no enforcement.

- Psychotherapists and clinical psychologists are the 'specialists' and have more freedom in choosing a treatment modality. Although the guideline can indicate the length of the therapy, there is still a lot of freedom.
- Psychoanalytic psychotherapy, including long-term psychoanalytic psychodynamic therapy, is recognized in the Dutch "zorgstandaarden" as a valid and insurable treatment for mental health care, provided it meets evidence-based standards and is delivered according to professional guidelines.
- The "zorgstandaarden" and associated guidelines focus on psychotherapeutic modalities with a strong evidence base for effectiveness, clear structure, and defined duration, such as psychoanalytic psychotherapy (typically 1-2 sessions per week, time-limited or open-ended but not as intensive as classical psychoanalysis).
- Psychoanalysis is not recommended by the guidelines.

The guidelines (zorgstandaarden) for psychoanalytic modalities

Therapy	Main indication	Duration/Intensity	Key focus
Psychoanalytic psychotherapy	Depression, personality disorders	40–60 sessions, 12–18 months	Insight, personality change
MBT	Borderline, emotional/interpersonal instability	Long-term, intensive	Mentalization, relationships
TFP	Severe personality disorders	Long-term, intensive	Transference, identity
KPSP	Chronic mood/personality problems	Short-term	Support, insight
ISTDP	Broad, esp. personality disorders	Short- or long-term	Emotional processing
AFT	Anxiety, depression, avoidance	Short- or long-term	Affect tolerance

Up till recently there was no control on the amount of sessions or length of treatment

Other regulations issues

- Couples therapy is not covered by the health insurance and must always be self-financed.
- Few forms of therapy may be combined (group and individuals, but also different therapies by two professionals provided different diagnosis is addressed).
- Groups are usually led by two therapists, and this is not related to the size of the group.
- Each BIG diploma/registration can only be obtained from an institution recognized by the Minister.
- To keep the BIG registration there is a re-registration procedure event 5 years. This requires a minimum of 3120 hours of relevant work experience (average of12 hours a week), further training (different for each BIG).
- Kwaliteitsstatuut: uploading information concerning the way you work and how things are organized at the (private) practice in a governmental locket and declaring to work by the rules. This supposed to reflect working by the demanded standard.
- We have to upload an accurate information about the waiting list of the practice each month.
- Regulations are the same to all types of therapies.
- Confidentiality and privacy are very well (over)regulated since the introduction of AVG (GDPR (General Data Protection Regulation)) in 2018 and protected by the wet WGBO, meaning the Medical Treatment Agreement Act.
    - Any exchange of information with others may be done after getting permission in writing.
    - Any contact with patients (or about them) must be used via a secure network with double authorization system
- - Patients have the right to their records and everything in it. Since we use an electronic records system, they can read sessions summary after each session if they want.
- Regulations are the same to all types of therapies.
- Medical records must be kept for the duration of at least 20 years.

- A private practice must have a testament/will where all the information is available to retrieve in case unexpected something happens to the therapist

Overregulation and interference of insurance

Since the insurance companies pay the treatment and they work hand in hand with the Dutch authority of health (NZA) (the independent administrative body responsible for regulating and supervising the Dutch healthcare market. Its main function is to ensure that healthcare in the Netherlands is accessible, affordable, and of high quality for all residents) they obligate therapist, through the contracts, to obey some rules. For example:

- Some DSM diagnosis such as, adjustment disorders, work-related problems, relationship problems, learning disorders (dyslexia, etc.), parenting problems, primary insomnia, personality traits/minor complaints etc. are not covered by the insurance.

- There must be a referral from the GP, and we need to inform the GP about starting the treatment and report when it ends.

- We need to fill a short questionnaire at the start of treatment to asses/report the severity of the condition.

- Some insurance companies start requiring that we ask permission when treatment is more than once a week and longer than a year. This is anyway the case when you don't have a contract (which drive psychotherapist to have a contract)

- In order to get a contract from the insurance company (or renew the contract) one has to prove to work according to the rules. This happens by being 'visited'/controlled every 5 years (praktijkvisitatie).

- Insurance companies are allowed to do controls. Might a process of therapy have not been done properly the therapist will have to pay back the sum he grunted for the therapy (till few years after therapy was completed).

- We witness a change in the contracts offer from one year to the other every time adding more aspects to adhere to under the cause of "better quality of treatment, more transparency, more effective and costs reduction".

Other considerations

- EPD: electronic patient file. Even though the access of not relevant professional is denied in a clinic, once information is sent to the GP, this information is potentially visible to other medical specialist and pharmacies. As far as I know GPs don't have an automatic access to EPD of clinics or private practices.
- Via the EPD the sessions are documented and digitally declared at the insurance companies by a third party
- Patients have the right to refuse sharing information (privacy verklaring). In that case no information will be shared and the insurance company still has to pay the treatment.
- Lately insurance companies limit the amount of people per practice that can refuse sharing information. Practices where many patients refuse to share information seems to have extra controls.
- The regulations and "zorgstandaarden" have impact on the mentality in the country regarding what is considered a good therapy, what is accepted. There is an ongoing discussion within our organization regarding this topic.

Portuguese Legislation on Psychotherapy

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Introduction

Regulation of the psychotherapist profession varies across Europe. Some countries recognize psychotherapy as an independent profession with its own legal framework, while others restrict practice to psychologists or medical doctors. Oversight typically falls to national authorities or professional bodies. For example, the European Association for Psychotherapy (EAP) advocates psychotherapy as a scientific discipline, referencing the 1990 Strasbourg Declaration[6]. Regulatory approaches differ: Germany, Italy, Sweden, and the Netherlands restrict psychotherapy to psychologists and physicians; Austria, Finland, and Romania treat it as a separate profession. Usually, government departments or authorised professional organisations set title protection and training standards (Mozina, 2024).

Who is regulating the profession of psychotherapist in Portugal?

In Portugal, the profession of psychotherapist is not legally recognized as an independent profession. Psychotherapy is a type of psychological intervention performed by psychologists or psychiatrists, regulated by the Ordem dos Psicólogos Portugueses (OPP) for psychologists and the Ordem dos Médicos (OM) for psychiatrists. Both require completion of accredited training programmes to practise psychotherapy[7].

[6] Legal Position of Psychotherapy in Europe 2021 (Final).docx

[7] Estatuto da Ordem dos Psicólogos Portugueses | DR
Despacho n.º 15866/2010 | DR
Lei n.º 57/2008 | DR
Ordem dos Médicos

There is no legal framework for "psychotherapist" as a distinct title, allowing individuals outside psychology or psychiatry to use it, which highlights the importance of verifying credentials. Nurses[8] and social workers with relevant training may use psychotherapeutic techniques but are not officially recognized as psychotherapists limiting their opportunities in private practice.

Only psychologists and psychiatrists may legally use the title "psychotherapist," as recognized by the state. However, since these laws originated from the late 2000s, there are many other trained professionals practising as psychotherapists via scientific societies. This regulatory gap has delayed conclusive legislation, especially regarding accreditation for non-psychologists. After 2010 (Despacho 15866/2010), the problem lies on how to accredit professional non-psychologists as psychotherapists.

In addition to the professional regulatory bodies, Portugal has a state institute called ERS (Entidade Reguladora da Saúde)[9], dedicated to the oversight of healthcare services, including those providing psychotherapy. ERS is tasked with supervising clinics, private offices (consultórios), and other health units that deliver psychotherapeutic care, ensuring compliance with established standards of safety, quality, and transparency.

Registration with ERS is mandatory for all entities offering psychological or psychotherapeutic services. This encompasses:

- Independent practitioners (liberal professionals who issue receipts directly to clients)
- Clinics or health units providing psychotherapy
- Institutions operating under agreements or conventions

These regulations are designed to ensure that all providers are accounted for within the official health system and subject to uniform standards.

ERS is responsible for verifying that all facilities used for psychotherapy meet specific requirements concerning privacy, confidentiality, and suitability for health practice. These standards are put in place to safeguard patient welfare and uphold professional integrity across all psychotherapeutic environments.

[8] 5ª Assembleia do Colégio da Especialidade de Enfermagem de Saúde Mental e Psiquiátrica
[9] Decreto-Lei n.º 127/2014 | DR

ERS possesses the authority to supervise, inspect, and apply sanctions if necessary. In cases of malpractice, lack of registration, or non-compliance with health regulations, ERS can impose disciplinary measures.

What are the regulations in public and private sector?

Portugal's National Health Service (SNS)[10], established in 1979, adheres to constitutional principles of universal, generally free healthcare for citizens and legal residents. Following the 2008 financial crisis, underfunding of the public services led many clinicians to private hospitals, with upper-middle class individuals increasingly holding private insurance. While psychiatrists commonly work privately alongside public practice, psychologists are scarce within the SNS, so these shifts have little impact on their public sector roles. Overall, the problems with regulation of psychotherapy have little to do with funding.

Psychotherapy is not regulated as a separate profession in either the public or private sector. In the public system, regulation occurs indirectly via psychology and psychiatry. Psychotherapy is delivered mainly by licensed psychologists (OPP) and psychiatrists (OM) in hospitals, health centres, and community treatment units (focused on drug abuse), both inpatient and outpatient. The high demand and low response of the SNS, results in long waiting lists, prompting many patients to seek private practice. In 2017, only 917 out of nearly 5,000 qualified clinical and health psychologists were employed in the NHS. Approximately one fifth of registered clinical psychologists currently practise within the NHS, with most SNS psychotherapists having trained in systemic or cognitive-behavioural approaches[11] (Vasco et al, 2003). This configures *challenges in accessibility*: public sector psychotherapy is limited, with long waiting times, so private practice remains the main provider.

Private sector psychotherapy is also credentialed by independent training institutions (Scientific Non-Profit Associations) in modalities such as psychoanalytic, cognitive-behavioural, systemic, gestalt, etc. These associations are self-funded, with training members working pro-bono. Private practice regulation is market-driven, relying on

[10] Estatuto do Serviço Nacional de Saúde | DR

[11] Relatório Final do Grupo de Trabalho para análise, estudo e elaboração de propostas relativamente aos modelos de organização da prestação de cuidados na área da psicologia no Serviço Nacional de Saúde (Julho 2017) (Despacho n.º 13278/2016, de 7 de novembro de 2016)

professional associations and consumer choice rather than legislation. Patients should verify their therapist's credentials and training background. Despite greater availability, private practitioners often have long waiting lists and referrals occur via word of mouth to colleagues belonging to the same association.

Where is situated the psychoanalytical psychotherapy in relation with other psychotherapies?

Psychoanalytic psychotherapies are residual in Portugal's public sector. The number of psychotherapists in the Portuguese psychoanalytic community (covering psychoanalysis, group analysis, psychoanalytic psychodrama, art therapy, family and couples psychoanalytic therapy, etc.) is estimated between 800 and 1,000 practitioners registered in accredited associations[12]. Most psychodynamic psychotherapists work in private practice, although recent years have seen an increase in NHS psychotherapeutic groups, often led by interdisciplinary teams rather than group analytic specialists. Hospitals encourage group interventions due to economic and time efficiencies.

A study (Branco Vasco et al. 2011) found that Portuguese psychotherapists typically integrate interventions in two ways: psychoanalytic and psychodynamic therapists rarely mix models, while cognitive, behavioural, humanistic, and systemic therapists often do. The tendency for psychoanalytically oriented therapists to avoid integration may explain their limited presence in the SNS. The rise in eclectic or integrative therapists reflects a broader trend towards integration in psychotherapy, likely influenced by research emphasizing evidence-based interventions—attractive to newer practitioners (Chambless et al., 2008; Nathan & Gorman, 2002; Roth & Fonagy, 2006 quoted by Vasco, 2011). However, there is little knowledge about who these integrative therapists are or how they practice integration (Vasco et al, 2011).

Is there any link between psychiatrist and psychotherapist?

In the public sector, psychologists work within interdisciplinary teams comprising psychiatrists, social workers, nurses, and educational/occupational therapists. Patients are

[12] Federação Portuguesa de Psicoterapia

referred to these teams, which determine treatment programmes. Within primary care centres, psychologists are typically evaluators due to high demand, making regular psychotherapy sessions rare. Public sector psychiatrists predominantly follow a biological/pharmacological paradigm and rarely engage in psychotherapies.

In private practice, coordination between psychiatric and psychotherapeutic treatments depends on individual clinicians. In 2024, the OM and OPP jointly recommended the General Health Department (DGS) establish norms for psychotherapeutic practice, signaling alignment between regulatory bodies regarding psychotherapies.

Who refers the patient to the psychotherapist?

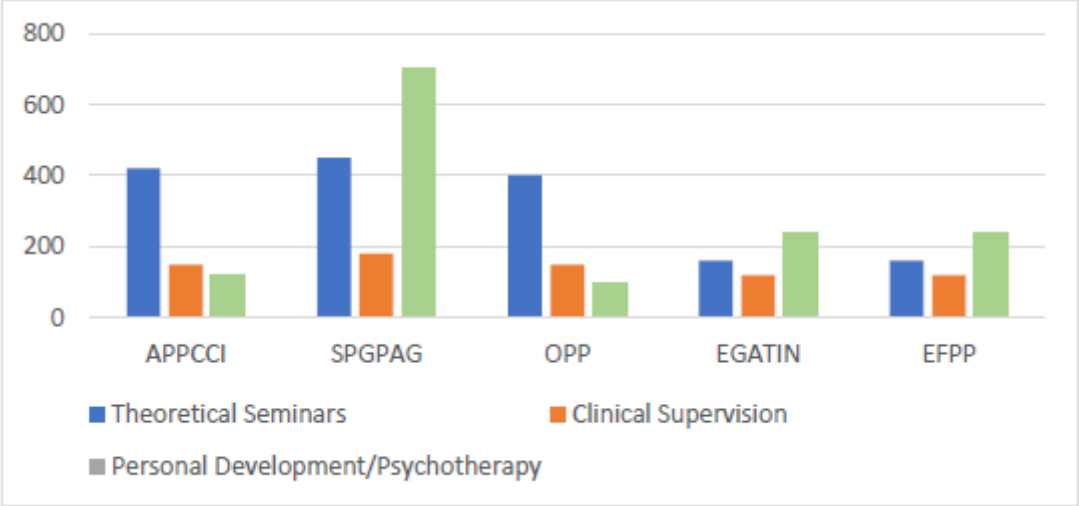
Private sector referrals are predominantly by word of mouth. In the public sector, referrals are made by general practitioners in primary care or emergency doctors, with patients assigned to any available professional.

Are there different regulations for different types of psychotherapies?

Training standards for Psychoanalytic Psychotherapies are rigorous and fully self-funded by professionals. There are variations between institutions, notably between analytical and cognitive-behavioural approaches. Cognitive-behavioural training typically requires "personal development," while analytical modalities demand personal analysis or a psychotherapeutic dynamic process. (Neto & Biscaia, 2019)

Comparison between several associations/organisations credentialing psychotherapists

	APPCCI	SPGPAG	OPP	EGATIN	EFPP
Theoretical Seminars	420	450	400	160	160
Clinical Supervision	150	180	150	120	120
Personal Development/Psychotherapy	120	700	100	240	240



Who can become a psychotherapist?

Officially, only psychologists and psychiatrists are recognized for tax purposes. Psychologists must complete a master's in clinical psychology and further training with scientific associations acknowledged by the OPP, typically taking 4–7 years, fully self-funded with no scholarships (Neto & França, 2021). This system ensures strong motivation but may exclude talented individuals from lower economic backgrounds, perpetuating the notion that psychodynamic psychotherapies are for the economically privileged people. Recognition for psychiatrists is comparatively easier, though they currently show little interest in psychoanalytic modalities.

What is the state´s vs insurance companies' responsibility in Psychoanalytical Psychotherapy?

Until recently, private insurance companies did not cover psychotherapy. ADSE, a system for public employees, covered 10% of costs. Other cooperative insurers (e.g., for bank workers) also contributed, though utilization was low due to privacy concerns. Since the pandemic, private insurers have increasingly supported psychotherapy, typically up to 10 sessions per year or a modest amount. If patients pay privately, costs may be deducted as health expenses on their taxes.

How is the issue of professional secrecy handled?

Each association has its own code of ethics, with OPP[13] and OM codes also applying. Portuguese law protects both clinicians and patients. The Code of Ethics for Psychologists mandates professional secrecy for all client data obtained in sessions, assessments, or other professional interactions, whether verbal, written, or observed, including clinical, family, and identifying information. Confidentiality is a cornerstone, with three exceptions: (1) imminent risk to client or third parties, (2) legal obligations (court orders or serious crimes), and (3) informed consent from the client for data sharing.

In the public sphere (within the SNS or institutions financially supported by the state) psychotherapists must maintain mandatory clinical records in the RSE (Registration System for Health Services), ensuring traceability and continuity of care. These records include user identification data, reason for consultation, clinical assessment, treatment plan, and follow-up progress.

The Portuguese Order of Psychologists (OPP) stipulates that these records must be objective and include only clinically relevant information, respecting the Code of Ethics.

The SNS24 (National Health Service 24-hour helpline) allows users to consult part of their records (medication, allergies, health habits).

Therefore, professional secrecy is highly valued even in the public sphere. Records are accessible only to authorized healthcare professionals - *Psychotherapists should avoid overly intimate or detailed descriptions, recording only what is necessary for the continuity of care and only in cases of serious risk to the user or third parties can confidentiality be broken, and even then, proportionally.*

Conclusion

In Portugal, psychoanalytically oriented psychotherapies remain relatively scarce within the public health system. This situation is largely the result of years of public policies that have neglected mental health, leading to a significant deficit in the education and training of health professionals in this area. Consequently, there has been a growing tendency to favor

[13] Estatuto da Ordem dos Psicólogos Portugueses | DR
Despacho n.º 15866/2010 | DR
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a manualized and technical approach to psychotherapy. This shift has resulted in an increased presence of cognitive-behavioural psychotherapists within the public sector, often at the expense of other therapeutic modalities.

Furthermore, psychiatrists and other medical doctors have, in a bid to maintain their coordination roles within hospitals, contributed to the marginalization of influential psychodynamic psychotherapists. Many of these professionals have opted to focus their work in private practice, where they can retain greater autonomy and flexibility in their clinical approach.

The current system, therefore, can be seen as elitist, restricting the general population's access to comprehensive mental health care. There is a significant concern that the state may intervene and legislate in this field without adequate understanding of psychoanalytic psychotherapies. Such intervention could be driven by bureaucratic and economic interests, often influenced by insurers and pharmaceutical companies—entities whose priorities may not align with the ethical and clinical needs of the profession.

Despite these challenges, there are several semi-private institutions, partially funded by the state, that offer mental health services to individuals with low incomes. Additionally, nearly every scientific society, such as the SPGPAG, operates social programmes designed to provide therapy at reduced costs for those in need.

While the predominance of private practice has its drawbacks, it also allows scientific societies to maintain their independence. This autonomy enables them to pursue rigorous and intensive training programmes, conduct scientific activities free from external economic or political pressures, and uphold psychoanalytic ethical principles. Most importantly, it supports the defence of humanistic values such as patient dignity and autonomy.

The remembrance of the Estado Novo dictatorship, which ended just over half a century ago, continues to influence attitudes toward authority and privacy. People still recall – and we hope they won´t forget - the intrusive practices of the political police, who kept detailed files on individuals and their families. This historical context underscores the importance of safeguarding confidentiality and professional independence within mental health care.

The professional community is concerned that political recommendations from the European Union, especially those imposed by economically dominant countries, such as the electronic patient file, will undermine the core values and goals of the profession, settled in humanistic values of trust and hope. The commitment to these principles remains strong among practitioners in Portugal.

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Book Review & Reader's Digest

Italian National Network EFPP Conferences

Soci Italiani European Federation for Psychoanalytic Psychotherapy (SIEFPP)

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The Italian National Network of EFPP (SIEFPP) has organised a yearly National Conference since 2013, with the participation of the 15 Italian Associations which represent the four EFPP Sections (Adult, Child & Adolescence, Couple & Family, Groups). Prior to 2013 we organised conferences in 1995, 2000, 2001, 2003, 2005 and 2008.

It gives us great pleasure to be able to share with you the topics of the past five annual SIEFPP conferences that have become a stable feature in our societies and national network.

The conference normally lasts one day. The morning is usually dedicated to a lecture, a dialogue with a guest speaker and a round table discussion. Every year, each of the sections participates in the round table discussion.

Delegates and non-delegates from the 15 associations are invited to take part in these working days, but guests from the Italian Psychoanalytic Society (SPI) as well as other European Psychoanalytic Societies are also invited. Special guests who represent the cultural world of literature, physics, linguistics, ethology, amongst others are always present, which enriches the dialogue.

Perhaps what best characterises our conferences is the afternoon work in which students of different training institutes of psychoanalytic psychotherapy present clinical papers regarding their therapeutic work. These are discussed in small “intervision” groups, with two Chairs belonging to different sections, therapists who normally work with adults, children, adolescents, couples, families or groups. It is easy to imagine the richness of such interactions which give way to associative ideas and deepening of understanding of the clinical material. It is a fruitful attempt to integrate the multiple levels of meanings which the session can have.

A possible translation of the book titles of the last 5 years could be as follows:

2021 Taking Care During Emergency - *Prendersi Cura nell’Emergenza*

L'evento epocale che inaspettatamente si è manifestato nel terzo millennio ha portato a una trasformazione degli scenari mondiali sovvertendo i sistemi economici e sociali. La reazione delle popolazioni, durante la pandemia, ha spinto a una nuova modalità di comunicazione, in realtà già esistente ma scarsamente sfruttata, in cui la digitalizzazione e il web hanno avuto un ruolo decisivo aiutando a rompere l'isolamento e a scongiurare un mutismo relazionale che avrebbe ulteriormente aggravato le conseguenze dell'emergenza pandemica. In questo volume vengono raccolte le testimonianze di psicoterapeuti e psicoanalisti che con dettagli esclusivi e testimonianze dirette mettono a disposizione dei lettori le modalità di intervento e di ascolto della sofferenza mentale e delle emozioni emerse durante il periodo dell'emergenza pandemica, mostrando, con ricchezza di particolari, i punti di riferimento e gli strumenti che hanno permesso loro di non sentirsi soli nell'affrontare il caos montante che coinvolgeva bambini e adolescenti, adulti e anziani, facendo ricorso a tutte le potenzialità che la prospettiva analitica possiede.

2022 Taking Care in Uncertainty - *Prendersi Cura dell’Incerto*

A due anni dallo scoppio della pandemia Covid-19 la SIEFPP tira le somme invitando psicoterapeuti e psicoanalisti a confrontarsi su come il setting si sia modificato e sulle emergenze inaspettate che sono comparse guardando un futuro ipotecato dalle minacce del virus e da un focolaio di guerra che mina non solo l'assetto europeo ma mondiale. Nuove

paure si affacciano e profetici appaiono sia i versi di *The waste land* di T.S. Eliot che il titolo del convegno stesso: *Prendersi cura dell'incerto*. Vengono in mente le parole di Freud "La morte oggi non può essere rinnegata; siamo costretti a crederci. Gli uomini muoiono veramente; e non più uno alla volta, ma in gran numero, spesso a decine di migliaia in un giorno solo. Non è più qualcosa di casuale ormai". L'uomo, ormai protagonista e demiurgo distratto di questo antropocene ha fatto già i conti in passato con pandemie, catastrofi naturali e guerre. La psiche ha necessità di un contenitore adeguato ai tempi e la psicoanalisi e le psicoterapie psicodinamiche hanno compreso che il setting non può essere considerato come uno spazio fisico e mentale asettico e staccato dalla realtà. In queste pagine la testimonianza, ardua e talvolta terribile, degli psicoterapeuti che hanno cercato di fronteggiare l'incerto.

2023 Tiresias' Doubts - *I dubbi di Tiresia*

Uscendo finalmente dal lungo periodo pandemico ci si rende conto di quanto esso abbia cambiato non solo il nostro modo di vivere, ma anche il nostro modo di pensare, di sentire e di essere. Dicevamo: «Nulla tornerà uguale, non saremo più gli stessi» e oggi sappiamo che è vero. Per quanto riguarda il lavoro degli psicoterapeuti oggi più che mai essi sentono che non possono illudersi di prescindere dalla realtà esterna, isolandosi nella stanza di analisi come in una bolla asettica e che sono chiamati a occuparsi del come gli accadimenti reali ricadono e riverberano nel mondo interno dei pazienti e di loro stessi.
Gli eventi traumatici oltre che devastazioni e lutti mobilitano risorse vitali e creative, inducono cambiamenti. È giunto il tempo della riflessione su come questo sia avvenuto e continui ad accadere, in un processo trasformativo che non ha mai fine. Attraverso quali relazioni avviene la trasformazione? E quali nuove relazioni nascono in noi sia dalla elaborazione dei lutti sia dalle forze vitali, dal richiamo del futuro, dall'impulso creativo che ci permette di trovare forme nuove? E poi il dubbio: stiamo uscendo dalla pandemia, o forse no? Viviamo con il Signor Dubbio, e, forse, abbiamo incominciato anche ad amarlo.

2024 Crossing Beyond Boundaries - *Sconfinamenti*

"Viviamo con il signor dubbio e ci stiamo abituando ad amarlo". Questo è il dilemma che ci ha assillato in questi ultimi anni. In questi anni progressivamente ci siamo dovuti confrontare con eventi al limite che implicano la natura, i comportamenti, i rapporti sociali. Lo spostamento verso il limite ci ha messo di fronte a molti dubbi sul come porci come psicoterapeuti rispetto ai nuovi contesti che insieme ai nostri pazienti ci troviamo ad affrontare. Siamo chiamati con urgenza ad intervenire in questi ambiti, "sconfinando" in campi e modalità di lavoro che a volte potrebbero non rispondere alla prassi classica che ci appartiene. È il nostro modello psicoanalitico che funge da faro in situazioni a volte nuove e molto complesse. Abbiamo lavorato nell'urgenza del Covid-19, della guerra, delle catastrofi naturali, ma soprattutto in inediti contesti sociali, dovendo intervenire a volte fuori dalla stanza di analisi. Ci troviamo di fronte a delle sfide che dobbiamo affrontare sia come veterani che come giovani analisti. Bion ricorda che "la psicoanalisi non può contenere il campo psichico perché non è un contenitore ma una sonda", ed è quindi attraverso questo mezzo che possiamo "sconfinare" senza perderci. È un tema che tocca trasversalmente tutte le modalità di prendersi cura: bambini, adulti, coppia famiglia, gruppi. Un argomento che ci pone dinanzi a una differente prospettiva arricchita da esperienze inaspettate e inedite, che consente di separare, ma anche unire, il confine e il suo superamento attraverso sfumature che si incontrano e si intrecciano definendo uno scenario nuovo.

2025 Contemporary Metamorphosis - *Metamorfosi Contemporanee*

In molteplici miti della nostra tradizione (Dafne, Medusa, Narciso, Clizia, Adone, Aracne...) l'esito di una violenta intrusione è raffigurato attraverso la metamorfosi: la trasformazione di un essere umano in qualcosa di diverso da sé. Nel modello ferencziano dell'esperienza traumatica la risposta autoplastica ha luogo quando l'individuo non è in grado di fare fronte alla pressione esterna contenendola in maniera alloplastica, ossia agendo opportunamente sull'extrapsichico. Un gruppo di psicoterapeuti e psicoanalisti si interroga sulla possibilità che il modello della metamorfosi sia utile per descrivere la processualità dei cambiamenti che stiamo vivendo ai nostri giorni. Nella prospettiva della disciplina psicoanalitica ci si chiede se in seguito all'esperienza pandemica non sia la Psicoterapia Psicoanalitica stessa a sottostare

a una metamorfosi. Il contributo al dibattito del premio Nobel Giorgio Parisi poi, ci offre una visione particolare per una ulteriore sfida che il pensiero psicoanalitico deve affrontare. L'incedere del nuovo si confronta con i nostri usuali paradigmi di pensiero: l'intelligenza artificiale, la logica binaria, l'ibridazione uomo-macchina, le differenze culturali. Ci domandiamo se sia possibile sostare ancora una volta sull'area liminale dell'ignoto, per disporci ad accoglierne la sfida e continuare a vivere attraverso di esso.