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Which configuration?

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ABSTRACT. – The authors aim to present in the form of a dialogue between two psychoanalysts, Psi1 and Psi2, some theoretical and practical controversies encountered in Relational Psychoanalysis and, more generally, in the field of psychoanalytic psychotherapy. The two clinicians discuss in depth the concept of 'configuration' in relational psychoanalysis, questioning its meaning and clinical application, and highlighting the complexity of the method. The debate begins with the concept of trauma and where it stands in relation to the configuration of the I-Subject. Psi1 highlights the unsaturated nature of meta-criteria, warning of theoretical self-referentiality, while Psi2 focuses on the importance of clinical practice and understanding the specificity of the patient. Through this comparison, the authors offer an open and flexible view of the clinical perspective, aiming to respect the uniqueness of each individual.

Key words: configuration; meta-theory; relationship; trauma; unsaturated; method.

'The only knowledge that is worthwhile is that which feeds on uncertainty
and the only thought that lives on is that which maintains itself
at the temperature of its own destruction.'
E. Morin

Introduction

Dialogue is a well-known form of expression in psychoanalysis: we are often called upon to analyse protocols and clinical cases, which are actually dialogues in two voices between patients and analysts. Yet dialogue between professionals is something we rarely find when analysing under the microscope. In this sense, the dialogue called 'which configuration?' represents a means through which to seriously (and not seriously) inhabit the Relational Psychoanalysis approach in terms of method. The theme that connects the dis-

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cussion between the interlocutors, two psychoanalysts called Psi1 and Psi2, is the shift from an objective theoretical reading of reality to a meta-theoretical reading, through an analysis focused on links and associations rather than on the search for truth.

Precisely for this reason, the two-way dialogue between psychoanalysts is a bold, critical, and self-critical key to the lenses through which we view reality.

Specifically, in this dialogue, a discussion emerges between Italian Relational Psychoanalysis Society (SIPRe) psychoanalysts, each with their own varied perspectives and interpretations regarding the clinical meaning of the meta-criterion 'configuration' in psychotherapy. The focus is on theoretical, meta-theoretical, and clinical issues, questioning the concept of configuration, the impact of trauma, and, ultimately, the purpose of psychoanalysis.

The configuration of the I-Subject emerging from this exchange challenges conceptual immobility and embraces the fluid, multifaceted nature of human experience.

Psi1 and Psi2 waver between the search for a perspective that valorises the richness of individual experience, and the need to share theoretical concepts which guide clinical reasoning: the dialectic between understanding and explanation, between clinical practice and theory, is staged in a logic of complexity, a recursive interaction in which one voice does not exist in the absence of the other, but can express itself precisely thanks to the existence of the other.

In the field of psychology and psychoanalysis, the debate on understanding the nature of the human being has generated a rich range of theoretical perspectives: according to our methodological approach, these perspectives are not to be mitigated or feared, but rather questioned with curiosity and boldness, with the intention of one who does not aim to absolutize them or transform them into theoretical statutes so luminous as to be blinding. An animated confrontation is not intended to point to losers or winners. It does not result in clear or incompatible positions. This work suggests that the challenge lies not so much in individual positions as in the intricate questions which, brought together in a dialogue, seek to probe the depth and complexity of the human condition.

It is important to emphasise that this work, the dialogue itself, and the theme of configuration, actually act as vehicles which present complexity and, hence, the 'method'. The emphasis is on the process, on the curiosity expressed, on the difficult questions that emerge, even those we secretly ask ourselves for the sole reason that, because of their nature, they cannot have definitive answers.

The dialogue ends with a reminder of the need to maintain an open and flexible perspective, considering meta-theory as an unsaturated conceptual tool that takes shape in relation to the content brought by the patient. The

article suggests that the understanding of configuration should focus on the centrality of the specific I-Subject, avoiding theoretical self-referentiality and keeping alive the tension inherent in the unsaturated nature of meta-criteria.

Dialogue

Psi1: Here everyone is saying that trauma does not exist...
Psi2: Well, alright... if there is no trauma, there is no mother.
Psi1: Mum is always mum!
Psi2: And trauma is always trauma.
Psi1: In what sense?
Psi2: Well, the term trauma indicates damage to the organism due to an external event, such as a collision or impact.
Psi1: And what was the organism before?
Psi2: In what sense?
Psi1: Before the trauma, what was it?
Psi2: Umm... well, in some ways, it was a slightly different organism. Because trauma makes you see things differently and makes you react to events differently. After a trauma, the organism becomes hyperactive when faced with a trigger stimulus, it's a matter of arousal, and hyper reacts to the point of experiencing post-traumatic stress.
Psi1: But have you studied these things?
Psi2: I have.
Psi1: And there is always that problem. That the I-Subject is one. Divided into parts. Which interact with each other.
Psi2: What's that got to do with it?
Psi1: We cannot believe that the I-Subject is its arousal, nor that the arousal is a detached piece of the I-Subject!
Psi2: Ok, I get it, I know these things, I attended SIPRe too. But, just between the two of us, we can state that, fine, the I-Subject is one, but trauma is an external, negative event that acts on the patient, in some cases it has a psychopathological impact and somehow deviates the individual's evolutionary trajectory. We cannot deny the drama of the trauma and we cannot deny that when the patient is there, facing us, we help him to process it.
Psi1: Trauma, like arousal, is not the patient and cannot be a detached piece of the patient acting on him. Do you remember the self-eco-organisation? 'The I-Subject is in reality, which is in the I-Subject'?
Psi2: Well all right, but concretely... Take COVID for example: after the COVID event whenever someone sneezed on the tube, people reacted as if that person had the plague. And there was a reason for that: it was a pandemic, a catastrophe! We cannot take refuge in the clouds, close our eyes

and cover our ears, and deny the impact on people's psychological well-being!

Psi1: All right. Ok. Let us assume that trauma exists and is an external event. And that we, by detecting its impact, can help the patient to process it. But that same event has different effects on people. Not everyone reacted to COVID in the same way. How do we know the details of why that patient reacted in one way or another, and for what reason?

Psi2: We know because, when working with the patient, through Presence to One Self, we come to understand his or her configuration. And how this is then implemented and modified. A patient with obsessive traits, when confronted with the COVID event, will react differently from a patient with psychotic traits: the former will probably reinforce his control solutions over the external random environment. The latter, hetero-regulated, will finally feel at home. Therefore, I can help the patient if I have in mind who that patient is and why he is suffering: only then can I read his historical solutions and understand why they are no longer working at this moment. Through Presence to One Self, the patient will be able to start from himself, take hold of his solutions and his becoming, and access creativity.

Psi1: So, Presence to One Self is a technical tool which allows us to understand the configuration of the I-Subject?

Psi2: That's right.

Psi1: But the Presence to One Self of whom?

Psi2: Of the analyst and therefore of the patient.

Psi1: Do you self-administer your Presence to yourself and then instill it in the patient?

Psi2: No, I go into supervision.

Psi1: At least that!

Psi2: I'm not as good with words as you are! But, I repeat, between the two of us we can be clear. In analysis, I help the patient to see himself for what he is.

Psi1: No way.

Psi2: Yes. To grasp...

Psi1: The apple.

Psi2: No. The configuration!

Psi1: To grasp the configuration?

Psi2: That's right, that's what I'm there for. Of course, I need some time to get to know the patient, but the first sessions are really useful, I'm not saying we need to carry out a recent as well as remote anamnesis in the psychiatric sense, but we need to understand who that patient is, his personal, family and cultural history, his relationships and experiences. To understand why he is suffering and why he has come to us at this time. In other words, the first interviews are for me to understand his configuration.

Psi1: I am not sure I would undergo analysis from someone who is convinced he can understand my configuration in three interviews.
Psi2: Maybe you are afraid of your configuration.
Psi1: Maybe I am afraid of you and how you inhabit your role.
Psi2: OK, we are psychoanalysts, we don't need to get personal. Don't worry, don't be afraid. Let's take a step back. How would you proceed with the patient?
Psi1: Umm... it's very difficult to answer your question because I don't think I am capable of knowing the configuration.
Psi2: That may be the case initially. Well, how many interviews would you need?
Psi1: I think that even after fifteen years of psychoanalysis I cannot claim to know the patient's configuration. I cannot know the other for what he is.
Psi2: I cannot know the patient for what he is and we agree on that. But I can know the configuration. Otherwise, what is there to work on?
Psi1: 'What' do I work on?
Psi2: Yes.
Psi1: If I had wanted to work 'on things' I would have become an orthopaedist or a butcher.
Psi2: Hmm, that's your obsession with words, one can't really say anything anymore! I'm not an orthopaedist either. But you're still not explaining to me what you mean by configuration and how you work!
Psi1: Well, first of all, let's start with the fact that I don't work on things. I don't work, therefore, on people, who are not things. I don't even work on configuration. Which is not a thing.
Psi2: Wow that's good. All very coherent. I guess that if configuration is not a thing, I can't even ask you what it is.
Psi1: Ok, let's start then with the one thing we agree on. The meta-theory of the I-Subject is formulated in Being and Becoming, right?
Psi2: Indeed. I'll get the book, here it is. Michele (Minolli, 2015), page 113, line 25, chapter 4, paragraph 6. Here he identifies the three moments in the process of the I-Subject.

The first is configuration and he says (and I quote):

1. 'The meta-theoretical assertion that genetics and the environment configure the I-Subject indicates that prior to conception that I-Subject does not exist.'
   In short, there is no pre-existing subject who decides who to be.
2. And again: 'it is an oxymoron to believe that the external is not instructive at the moment of conception'.

For you, who are so good with words, I'd like to recall an example of an oxymoron: deafening silence. Putting two opposite concepts side by side. It

is clear that in the zero moment of life, eco-organisation prevails. That egg and that sperm are not of the I-Subject, who did not choose to be born.

Let us go back to Michele (Minolli, 2015):

'In the moments following zero, for all the stages that constitute life, the I-Subject will inevitably function on mutual incidence BUT will do so within the initial and original configuration'.

Therefore, in the zero moment of life the subject is configured from the outside. From there he exists, and from that moment he functions in a relationship of reciprocal incidence with the outside, on lines of strength that are inscribed within him. Reciprocal incidence has configuration as its referent.

Psi1: What does this mean in clinical terms?

Psi2: That first I know the configuration and then I see how the patient, in his reciprocal incidence, implements it with his historical solutions and, eventually, modifies it.

Psi1: So the patient implements and modifies the configuration!?

Psi2: Yes, it says so!

Psi1: Does he also wear it to go out in the evening?

Psi2: …

Psi1: We agree on the contents of Being and Becoming. But I don't think the point of this discussion is the contents. The sense lies in what we do with them and how we use these meta-theoretical indications in our clinical practice, i.e. in the encounter with the specific I-Subject. Furthermore, it isn't written that the configuration changes, because it simply does not change.

Psi2: The configuration does not change? How can I help the patient if the configuration does not change? Does it stay the same for life?

Psi1: One thing at a time! Let's start with single items:

The discourse starts, and I quote, with 'the meta-theoretical statement' because configuration is a meta-criterion of the meta-theory of the I-Subject. Configuration, consciousness and creativity are the three meta-theoretical moments of the I-Subject process. They are precisely on the same epistemic level: no one would ever say that it is possible to know, foresee or control the creativity of the I-Subject, because it is the patient's own. I do not even believe that anyone would propose to measure it or to understand at what session number 'creativity' is triggered. Not because it is forbidden to ask, but because this kind of question - if interpreted in a concrete sense - does not really make sense. The same identical discourse must be made about configuration.

Psi2: Ah.

Psi1: The configuration is introduced primarily to enhance the centrality of the specific I-Subject. Minolli (2015) explains this clearly on page 119: «*The I-Subject is not a timeless, a-priori entity wandering about in sidereal space waiting for the moment to become incarnate. To argue that*

the I-Subject is configured by genetics and the environment is a meta-theoretical point of view which allows the individual and specific I-Subject to be taken into consideration. The I-Subject is what it is because it is the result of the modalities that configure it. It is these that make that concrete and singular I-Subject exist. It is this unique being that makes it a 'special thing'.»

Psi2: Eh, yes, the I-Subject is special...

Psi1: I really don't understand. How can we think about working on the configuration if we don't ask ourselves how to work with a meta-criterion?

Psi2: You've lost me.

Psi1: Configuration is a meta-criterion right?

Psi2: Yes.

Psi1: Have you ever wondered what that means?!

Psi2: That they are general criteria which say nothing about the specific subject.

Psi1: No.

Psi2: How so?

Psi1: It's not a criterion, it's a meta-criterion.

Psi2: Ok, so the map is not the territory

Psi1: Which means?

Psi2: I don't know, these are general guidelines. The contents are produced by the I-Subject, but in the meantime I know that it has a configuration, a consciousness and a creativity.

Psi1: You see, that's exactly the point, to clarify what epistemic statute we give to the concepts that accompany our clinical reasoning.

Psi2: You know, you're really getting carried away. Epistemic statute?

Psi1: Yes. In what way do they exist for us. In what way do we think configuration exists? We might go so far as to say that configuration does not exist either. Like trauma. Because configuration is not a thing, which I go looking for in the world. It is not an external theoretical referent that helps me to explain the patient.

Psi2: So that's the difference between theory and meta-theory?

Psi1: That's right! It is important to point out that the 'meta-theoretical' character is not explained solely by the fact that the criteria are found at a 'general' level of reasoning: we might think that meta-theory is something that, starting from its general criteria, makes us go beyond the criteria themselves, because they only take shape in communion with the contents brought by the I-Subject himself. And that is, in short, the unsaturated character of meta-criteria.

Psi2: But why do you insist on this? I am interested in the clinical aspects.

Psi1: Because if we do not clarify what we need a meta-criterion for, we risk falling into two different traps, precisely in the clinical encounters.

I need you to be patient and to come with me, just for a moment, to the clouds: there I will illustrate two types of dangerous reasoning which misunderstands the meta character of the meta-criterion.

Psi2: All right then, let's hear it.

Psi1: In the first case, the reasoning proceeds from the particular to the general and the contents are read and interpreted with the aim of 'filling' empty meta-criteria.

It is as if we were using the criteria like little boxes to be filled, and in order to fill them in we have to ask our patients questions to get information about their configuration or their parts. I know the patient has a configuration, what is it?

Psi2: Exactly! What is his configuration!? It's a question we ask ourselves sometimes in supervision, but according to this reasoning, maybe the risk is that we think only about filling the boxes, and lose sight of the patient.

Psi1: Exactly. It is as if the meta-criterion 'configuration', becomes merely a theoretical criterion, a grid to be filled in. This approach to reasoning is called the inductive method.

Psi2: And what would the second reasoning be?

Psi1: In the second case, instead, reasoning proceeds from the general to the particular and the criteria are used as if they were 'things' that epistemically take the place of the contents.

Psi2: Epistemically?

Psi1: Yes, in the sense that I have to know the criterion not the patient!

Psi2: Ok, for instance, I'd like to ask you 'when was the Configuration born?'

Psi1: And that's exactly where the misunderstanding arises, because we assume that the configuration is a physical 'thing', which walks in the world and can be measured. Beyond the specific patient. However, the configuration is not a thing and, above all, it is not the subject (who in turn is not a thing).

Psi2: It seems to me that the main risk in this method's approach is to focus exclusively on the theoretical aspect of configuration, ignoring the specificity of individual reality.

Psi1: The risk is precisely that of losing the richness and complexity of the individual's experience by focusing exclusively on a theoretical approach. In fact, this method is called deductive.

Psi2: And so, if we want to be neither inductive nor deductive, how do we get out of it?

Psi1: First of all, we can focus on the meta-theoretical value of the criteria, which lies precisely in the adjective unsaturated.

Psi2: This adjective 'unsaturated' has always seemed a little strange to me: almost 'unclinical' as a term.

Psi1: We will clarify it if we accept once and for all the fact that meta-criteria openly assume the ontological statute of concepts. They are conceptual tools which guide our clinical reasoning! However, they are unsaturated,

incomplete, and only take shape in relation to the contents brought by the patient. In other words, meta-criteria do not exist as independent entities, because they are not tangible things.

Psi2: Indeed, configuration also does not exist as a physical object because it is not a tangible thing!

Psi1: That's right! Meta-criteria are not to be filled by the patient (inductive) or nor do they substitute the patient (deductive), but constitute a continuous challenge for the clinician, if he is open and willing to be challenged, and, in particular, they question his method.

Psi2: Method? How can I concretely guarantee this?

Psi1: You can! It is just a matter of method! The method reflects on itself: method means taking the question of complexity seriously, that is, questioning oneself on how one observes the patient. Do I really need to ask him to confirm the truth revealed by my theory? The method is the real antidote to theoretical self-referentiality, because it allows us to keep an open and flexible perspective.

Psi2: But we don't risk being self-referential, because we don't possess a theory that tells us how the patient should be, but a meta-theory whose contents are brought only by the specific I-Subject.

Psi1: Exactly! But the meta-theory does not work on its own, it does not work just by declaring itself to be meta. It works when we therapists are willing to be the first to answer the question, and ask ourselves what we are doing with our glasses on our nose. Meta-theory frees itself from theoretical self-referentiality if it keeps alive the continuous tension inherent in its unsaturated character: this tension can be guaranteed by the method.

Psi2: Perhaps, in this sense, the real question is: why am I interested in knowing when the configuration was born? Ultimately, this meta-criterion was created to highlight that the subject is unique and has a beginning and an end. Ours is a clinical job.

Psi1: And clinical means meeting a person who is unwell and asks us for help. This meta-criterion was created for an encounter in a clinical context: it is not relevant to consider studying the configuration in a laboratory setting, or searching for it in people's brains with a magnetic resonance imaging!

Psi2: Ok, I'm willing to keep that tension alive. But I was thinking... everyone is upset if you can't change the configuration because it's as if you're telling me I'm condemned to be who I am.

Psi1: But if you think about it, it really is a false problem, because there is no way of knowing 'how I am' in an objectified sense. The configuration cannot be the objectification of the patient's being, because as a matter of fact the patient is always in a process of becoming and this process is always his own. So what use would a static photograph be to me of how the patient is? It is important to remember that the subject there, before me, moves on consciousness and not on configuration: consciousness is an

important meta-criterion because, clinically, it nails me to the patient who is before me, to the present, and not to the past.

Psi2: Indeed, configuration is a concept that is very reminiscent of the past.

Psi1: Exactly! And therein lies the risk! We can refer to Michele's (Minolli, 2015) article in response to Stephen Cooper, in which at least two reasons are given why thinking of the past, and thus the configuration, as an explanation of the patient's suffering leads us astray in the clinical encounter.

Psi2: Let's hear them.

Psi1: First, if I consider configuration as a thing, then the moment in which the patient was configured is a thing that still exists. In this logic, configuration becomes the reason why the patient suffers, the explanatory sense of his suffering.

However, thinking of configuration as the cause in itself of suffering, parcels out its meaning, parcelling out the I-Subject at the same time. And it causes us to lose sight of the I-Subject before us.

Psi2: If we think about it, when the patient arrives, he often brings a fatigue related to his way of being and the reality that does not confirm him: an insuperable fatigue, starting from the way he is. And, in 99% of the cases, his way of being is already linked in his narrative to how insufficiently good his mother was, for example...

Psi1: OK. Follow me for a moment. I quote Michele Minolli (2009):

'The theory of the past leads the analyst not to put the patient at the centre of his interest. Thinking of the past does not help to think of the patient as the subject of his history. In other words, a gap is created between the analyst's intention to be interested in him, and neglecting him by putting the theory of his past at the centre instead'. Now try replacing the word past with the word configuration, and think of considering the meta-criterion configuration as a simple theoretical criterion.

Psi2: Okay, I'll try: 'Configuration theory leads the analyst not to put the patient at the centre of his interest. Thinking about configuration does not help to think of the patient as the subject of his story. In other words, a gap is created between the analyst's intention to be interested in him and neglecting him by putting the theory leading to his configuration at the centre instead'.

Psi1: Eh.

Psi2: Oh.

Psi1: So what?

Psi2: So, that was the problem with the deductive method, the one you were telling me presents the risk of losing sight of the complexity and therefore of the patient.

Psi1: And just think, there's a second problem as well!

Psi2: Well fancy that!

Psi1: 'Thinking about the power of the past disempowers the patient'.

Psi2: Disempowers?

Psi1: Yes! It disempowers, i.e. deprives of authority! 'Even if it is difficult for us to admit it, when we make the patient's concrete past the explanation of his pathology, we assume that there is an ideal past. If the environment had been different, if the parents had behaved differently, if the brothers or sisters had been different, we would not have the pathology. An ideal is a criterion that we establish of how reality should be. An ideal is a model we create of how things should be'. (*Ibidem*)

If we consider configuration as a thing to know about the patient, if this is the way we use it in clinical terms, it does not favour a return to the self, but a return to the past. A general past, certainly, but not a meta-theoretical one: a general past, which serves as a regulative ideal on how to know the patient.

The configuration is not given to us therefore, we do not know who the patient is, and the configuration reminds us that we cannot know him but that this doesn't mean he is not there, right before us.

Psi2: Actually, if we think about it, it is very logical to admit that the I-Subject does not coincide with and does not access its configuration. We know that the I-Subject is one, composed of parts in interaction with one another. It cannot be substantiated in mental states...

Psi1: And, of course, he cannot be substantiated in his configuration! If the patient does not access his configuration, it is not by interpreting his configuration, or explaining to him how he is configured, that I encourage him to take himself seriously and walk on his own legs. It is a meta-theoretical moment that tells me that there was a time when the patient did not exist, and a time starting from which he existed, with eco-organising variables that configured him.

Psi2: OK, got it. Then I'll ask you the very last question.

Psi1: Shoot!

Psi2: If the configuration cannot be known as a thing, it cannot be measured and it does not change. Could you please explain to me what is the point of our work? Considering that patients seek change, how can we justify therapeutic practice if the nature of the configuration remains unchanged and cannot be understood as a tangible object?

Ps1: We all know this: psychotherapy has always been considered the personalised tool for change, but this view assumes that the analyst has a direct impact on the patient's path of change. In fact, this vision implies a structural asymmetry between patient and therapist, with the patient delegating to the therapist the search for the causes of his suffering.

Ps2: And we both agree on this.

Ps1: But are we sure that change is implicit in the patient's request? And do we really have to help the patient achieve change?

Ps2: Hmm.

Psi1: If we look at it from another perspective, no theory can offer an ideal model of a fully recovered patient. The patient carries with him a coherence that stems from the interaction between his inner and outer worlds,

and is also self-eco-organising in the relationship with the analyst. Following this logic, the interaction between patient and analyst need not aim at healing and change. No interaction is inherently instructive: and change cannot be decided a priori.

Psi2: And so what is the role of analysis?

Psi1: Perhaps the goal is not so much to change as to take the patient seriously for what he/she is.

Psi2: What if the patient is not the configuration...?

Psi1: It is not the configuration that must be taken seriously, but the I-Subject in the flesh!

Psi2: Evidently, if we managed to get a migraine in order to agree on this one point, taking the patient and oneself seriously is not at all easy.

Ps1: Yeah, taking the patient seriously implies respecting his or her ongoing process and trusting his or her ability to take charge of his or her own life from within.

Psi2: Now I understand.

Psi1: Then remember what Ceruti (Bocchi & Ceruti, 2007) said, '*the course of the living is never given a priori*'.

Psi2: Whatever. And so - just to clarify - trauma does not exist as a thing.

Psi1: Yeah, there are a lot of things here that don't exist as things.

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