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Interview with Mario Rossi Monti

*Laura Corbelli**

Laura Corbelli: I would like to personally thank Professor Mario Rossi Monti for agreeing to this interview during the Basic Course in Phenomenological Psychopathology (Florence, Italy, 2025). Mario Rossi Monti is Professor Emeritus of Clinical Psychology at the University of Urbino and a founding member and lecturer at the School of Phenomenological Dynamic Psychotherapy in Florence. Thank you for accepting our invitation.

I would like to make the most of this meeting, and on this occasion, on a day dedicated specifically to the psychopathology of instantaneity, I will start by asking you what is meant by this term and why it is relevant today.

Mario Rossi Monti: The theme of instantaneity refers to the attempt to account for new forms of mental suffering, taking into account some of the major changes occurring in our era. The key to instantaneity – that is, the shift in the lived experience of time in our societies – is probably one of the factors playing a primary role in the clinical manifestation of these new forms of mental suffering as well. When faced by these new forms, the old nosographic categories, with which my generation was trained, have revealed their inadequacy. A significant part of mental distress is now attributed to what we might broadly refer to as the borderline spectrum, in an effort to encompass both descriptive psychopathology (borderline personality disorder) and structural psychopathology (borderline personality organization) within the same framework. Within this area, we encounter a vast array of clinical phenomena – some of which are highly heterogeneous – that are difficult to account for in clinical-theoretical-nosographic terms. One interpretation that has been greatly emphasized in recent years is to attribute these forms of pathology to sociocultural changes, following argu-

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ments made also in the past, such as when attempts were made (unsuccessfully) to establish a cause-and-effect relationship between the capitalist organization of society and schizophrenic pathology. Today, many believe that the spread of borderline personality disorder is the product of what is termed a "borderline society". And yet the connection between contemporary clinical practice and sociopolitical organization is an extraordinarily complex one that cannot be resolved by applying a clinical diagnosis to the society in which we live. First of all, I wonder if it is legitimate to "diagnose" society. Freud was very cautious on this point. Today, there is no trace of that caution left. Socio-anthropological-clinical diagnoses abound. Philosophers and sociologists vie with one another in an attempt to capture the essence of our societies in a formula. To name just a few: the liquid society, the society of the image, the society of the spectacle, the society of transparency, the society of acceleration, the society of performance, the society of malaise. But also, drawing on clinical terminology, the depressive society, the excited society, the manic society, the borderline society, the psychopathic society, the bulimic society. This exercise, which draws its inspiration from Christopher Lasch's famous book on the narcissistic society of the late 1970s, seeks to define the essence of our societies using clinical terms, assuming that the clinician's position is a privileged one that allows for the generalization of what is observed within the clinical setting. A position that has always struck me as somewhat presumptuous, as well as naive. I also wonder how beneficial this approach is for clinical practice. If Freud had limited himself to saying that hysteria was a manifestation of the crisis of late-nineteenth-century bourgeois culture, we would likely still be stuck with Charcot's hysteria and would have missed the opportunity to develop an original line of thinking of extraordinary clinical and therapeutic usefulness. Today, perhaps this opportunity must be forged in light of the new forms of mental suffering that challenge us and regarding which we are, at the very least, disoriented.

LC: In the title of your talk today, *Borderland and Beyond*, you use a specific term: the "dumping" of patients. This is because these patients pose challenges even for services and healthcare providers. Could you say a few words about this?

MRM: The borderline condition manifests itself primarily in relationships. In reality, this applies to some extent to all forms of mental suffering, but it is particularly evident in borderline personality disorder. A melancholic person lives shut off in their own world, often contemplating suicide (which everyone today hypocritically calls "anti-conservative behavior"). They are prisoners of a way of being in the world that almost completely undermines relationships. The same applies, in a different form, to schizo-

phrenia, especially in the paucisymptomatic forms described by Blankenburg. The borderline clinical picture, on the other hand, is an extraordinarily interactive one. The therapist, the clinician, the psychiatrist, the psychologist, and the educator are drawn in by the patient and pulled into a relationship that I would not hesitate to describe as traumatic even for the clinician, who is confronted with intense emotions. These are the patient's emotions, but also (and perhaps above all) the clinician's own emotions.

When working with borderline patients, we have had to learn to function despite being caught up in emotional states that do not typically fall within the range of those traditionally considered characteristic of a therapeutic setting. From this perspective, Winnicott's pioneering work on *Hatred in Countertransference* (1947) has proven to be extremely valuable. I have always been struck by a statement by Peter Fonagy, who argued that it is not possible to be borderline on one's own. Drawing on Winnicott's famous observation that a human infant cannot exist on its own, Fonagy argues that there is no such thing as a borderline personality on its own. To be borderline, one needs a relationship that serves as the stage on which to enact a clinical reality that profoundly involves the other person.

LC: This inevitably brings us to the topic of diagnosis. We are living in times marked by intense events – from the Covid pandemic to wars and migration. What is the role played by diagnosis in this current moment?

MRM: Diagnosis covers a vast area. I believe we should speak of diagnoses in the plural. A nosographic diagnosis is important – indeed, indispensable – but it is only part of the work. Perhaps even the lesser part. It is a point of arrival, but also, and above all, a starting point for subsequent therapeutic work that goes beyond the diagnosis itself. It is always a provisional hypothesis. Jaspers said that each diagnosis should remain a source of torment for the clinician. It is not a fact established once and for all. In this sense, diagnosis should perhaps be understood more as a verb or a process than as a noun: "diagnosing" is more useful than the diagnosis itself. Today, we often encounter situations that are difficult to define using traditional diagnoses. This can present an opportunity, because we might meet people who are suffering intensely without having yet "categorized" their suffering into a structured disorder codified by clinical practice. In this sense, the work of psychotherapists has expanded to encompass a range of preclinical cases – evolving conditions that vary over time. Those who have learned to work with adolescent patients, where this set of conditions is always present, can now benefit greatly from this type of experience.

LC: This involves a process of interpretation that unfolds over time.

MRM: Absolutely. Long-term support helps us find a meaningful path even when we're initially groping in the dark. Even though it's becoming increasingly difficult to give ourselves the time to understand what's happening and to allow the necessary time for a process of change.

LC: What issue do you think is most pressing for young clinicians today?

MRM: I would say shame. It is a recurring emotion, difficult to handle. Simply mentioning shame evokes it. It is primarily physical and is often transformed into guilt. We can talk about guilt, but shame is more difficult. It is a sensitive subject. It is always very difficult to find a way to put this emotional state into words.

LC: Given your work on guilt and shame, I'd like to ask you how these ideas can inform clinical practice today.

MRM: By challenging established paradigms. Clinical practice evolves. Nosography, too, is a living body of knowledge. It changes over time. Clinical thinking must grasp the creative and functional aspects of symptoms. Today, a dangerous trend is to obscure complexity behind a proliferation of pseudo-diagnostic labels. Terms such as "externalizing disorders", "dysfunctional behaviors", and "anti-conservative behaviors", as well as mobbing, stalking, bullying and cyberbullying, burnout, hikikomori, eco-anxiety, emotional dependency, and compulsive shopping, describe a range of phenomena – some new and some less so – from the perspective of a third-party observer. No account is taken of the perspective that phenomenological-dynamic psychopathology has always prioritized: the first-person perspective. It is clear that, according to common sense, borderline self-harm is "dysfunctional" behavior, but from a therapeutic perspective, as a clinician, I must adopt the stance of someone who instead posits some "functionality" within the subject's psychological economy: if we manage to stay focused on the issue and explore it in depth, we will most likely find meaning in it.

LC: What have been your main sources of inspiration?

MRM: I like the image of the "inner family". Engaging in dialogue with the mentors I've met or with the authors I've come to know through their writings, as I converse with the patient. To name just a few: Jaspers, Minkowski, Winnicott, Bollas, and Ogden. Authors who bridge theory and clinical practice.

LC: A book you would recommend to young clinicians?

MRM: *The Divided Self* by Ronald Laing. A compelling book, grounded in clinical experience. To do this work, you have to get involved. The issue isn't whether to get involved or not (as young students are often mistakenly taught), but how to do it.

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