Original Article

Traumatic memories for another world

Ricordi traumatici di un altro mondo

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ABSTRACT

This clinical vignette examines the interplay between the detached, often defensive language of clinical practice, which can create distance from individual patient experiences, and a more empathetic, narrative-based approach that fosters the construction of meaning. Gio's experiences marked by loss, trauma, and abandonment reflect the fragmented and seemingly disconnected nature of his therapeutic interventions. The perceived difficulty of integrating his narrative leaves Gio feeling alienated from himself and his family. His story becomes a cycle of repeated beginnings, prompting crucial questions: how can we move beyond reactive, crisis-driven interventions to a proactive, choice-oriented model that disrupts the dynamics of reciprocal victimization? When interventions are delayed and focus solely on the «adolescent symptom», rather than addressing the broader family system, what are the prospects for meaningful change?

Questa vignetta clinica esamina l'interazione tra il linguaggio distaccato, spesso difensivo, della pratica clinica, che può creare distanza dalle esperienze individuali dei pazienti, e un approccio più empatico, basato sulla narrazione, che favorisce la costruzione di significato. Le esperienze di Gio, segnate da perdita, trauma e abbandono, riflettono la natura frammentata e apparentemente sconnessa dei suoi interventi terapeutici. La difficoltà percepita nell'integrare la sua narrazione fa sentire Gio alienato da sé stesso e dalla sua famiglia. La sua storia diventa un ciclo di inizi ripetuti, sollevando domande cruciali: come possiamo passare da interventi reattivi e guidati dalla crisi a un modello proattivo e orientato alla scelta che interrompa le dinamiche della vittimizzazione reciproca? Quando gli interventi vengono ritardati e si concentrano esclusivamente sul «sintomo adolescenziale», anziché affrontare il sistema familiare più ampio, quali sono le prospettive di un cambiamento significativo?

Case Report

I will recount Giovanni's story in the final phase of his fragmented journey, resigned through the psychiatric services of adulthood—a portrait of a boy who comes from elsewhere. The recurring themes in his story seem to be abandonment and fear, increasingly manifest in his agitation, the fear of finding himself repeating the same experience: being entrusted to other people once again—even in the seemingly legitimate and sublimated form of psychotherapy.

Children who have the opportunity to ask about the history of their own adoption are helped to mourn the loss of the emotional world of their origins. The same applies to the countless questions about the place and manner of their first meeting with their adoptive parents; this allows them to openly face the suffering of not being born to those parents.

Thus emerges, little by little, the lack of mental and emotional contact with the unknown worlds of origin, which reflects the difficult and painful construction of an emotional and mental bond with the adoptive parents: in this family's story, the impossibility of building something new is outlined, where perhaps fragments of memory integrate as parts of a broader narrative—hampered by a sort of prohibition on knowledge: «we must not talk about it because it would destroy our family».

I first met Giovanni on December 23, 2006. I only remember accompanying the boy, hospitalized the previous day in our adult psychiatry ward (in an Italian polyclinic), after taking an excessive amount of medication and attempting defenestration. I took him for an evaluation of his right foot and lower leg, suspecting a fracture from recent trauma.

I saw him in the corridor, accompanied by his father, who spontaneously introduced himself and offered to come along. It struck me as a good occasion to meet them together—it's not every day we get contact with the family. The boy is very young, born in 1988, but he seems even younger than that. Having someone introduce him and his story reassured me, because we would talk about this again during the scheduled meetings, despite my defensive rationalizations. (I'm not the doctor who will follow up with him; I'm the resident who happened to be on duty that afternoon, who accompanied the patient from the ward to the ER for radiological examination—I don't know how much of that to bring into this, because I won't be with him in the days to come.) Giovanni doesn't introduce himself; he greets me with his head down—a behavior typical of someone who has made a scene.

His father takes him in his arms, strokes his head, smiles at him and then at me, with worried eyes.

We leave the ward, which I unlocked, and take the elevator down to level -1. Giovanni tells us his foot hurts, speaking in a metallic voice with a "r" typical of Northern Italy, which contrasts sharply with his Brazilian toddler hues. I don't recall why, but he immediately provoked tenderness in me. This later surprised many of his aides and colleagues. Perhaps it's because I hadn't read his history yet, and encountering him—the youngest in an adult ward during the Christmas week—felt so sad that I would have forgiven any fault.

While Giovanni was finishing the radiographic exam, his father told me why his son was in our care. In recent months, G. had ended up in the ER several times; school wasn't going well; since October, he has been followed by Milan's SERD (the addiction services) because of increasingly frequent episodes of alcohol abuse—he goes three times a week—and for over a month he's been seen by Milan's CMP for "hearing voices".

Giovanni was adopted at six months by Giulia and Alessandro. When he was three, his parents decided to adopt another little Brazilian girl, Melania, and took G. with them back to the origins so that the arrival of three-month-old Melania could be experienced more naturally.

Nothing emerges about how the parents came to adopt, through the suffering of their inability to conceive.

G. is cruel to his little sister, at least that's what his mother tells us: he tramples her, insults her, and excludes her from games—unable to overcome the "sibling complex".[1] The mother will say that G. has always been mean, born that way; perhaps he was spoiled—yet there is something more, originating from his birth family, for which his adoptive parents are not responsible.

On the other hand, while a biological child might be seen as «that most familiar stranger»,[2] Giovanni is the stranger for whom—having come biologically from elsewhere—one can renounce impossible filiation through defensive rationalization.

In 1994, when G. was six, Silvia, the couple's biological daughter, was born. G. seems to accept her more easily; he prepares himself for her arrival and even wants to attend his mother's gynecological visits. Giulia is worried, as if she had exposed her son too early to the "violent and raw" things in life. It is also around this time that G. begins psychotherapy for aggressive behavior toward his sister, to whom he is pathologically jealous, say his parents—a vicious, senseless jealousy, according to his mother.

The records note that "psychological support sessions brought results and then stopped". Out of respect, precisely, for the family prohibition on access to knowledge—which may be better explained as "a prohibition to think and speak together about the anxieties related to his own diversity"[3]—G. doesn't remember how frequent the sessions were or why they stopped. It simply got better, and the same for his mother.

In 2000, his parents separate. G. begins weekly visits to a child neuropsychiatrist as verbal hetero-aggressiveness reemerges, initially toward his mother, then also toward his father, whom he blames for the marital breakdown.

"Abnormal behaviors because they seem designed to provoke the same old experience of rejection and expulsion by the adoptive family. The behaviors acted out could indeed lead to crisis, or even rupture current affective relations, evoking pathological identifications with an internal object that is unknown yet incapable of providing necessary care to a newborn or child, and so is experienced as deteriorated".[3]

In 2004, his therapist dies and G. is temporarily entrusted to the care of another child/adolescent neuropsychiatry service. Thus begins his disorganized, headless care path: pathologizing for G. and relieving responsibility for his parents, who were unable—or rather, insufficiently helped—to endure the entry into the family of thoughts felt as dangerous.

For my part, I began realizing, in this incidental yet precious corridor encounter during my on-call shift, what working with adoptive parents entails, because it requires close examination of one's own countertransference, and it seems impossible to manage alone—oscillating between alliances: with the parents against the unbearable children, then with the children against the parents whose listening capacity is exhausted before even being used.

The diagnosis shared by both therapists is "severe personality disorder with suicidal and homicidal impulses, with indication for community-based solution". His parents will say that he showed no pain or suffering regarding this abandonment, thus supporting the thesis of his innate wickedness. He lives with his father after a miserably failed attempt to live together with his mother and siblings in a small village near Pavia, where he attends middle school with excellent results.

After a difficult school trajectory, this year he enrolled at the Institute for Surveyors in Pavia, with good results according to teachers—but great difficulty, according to G., who has recently begun to feel maladjusted, despite the desire to attend this school (he later told me it wasn't a conscious choice or to please his mother, but to follow a friend). School failures were more due to his excesses than intellectual or attention-related difficulties.

The care path has been equally complex and fragmented: from the CPS receiving a first telephone call from SERD—seemingly most suitable for the alcohol abuse beginning in July 2006—to referral back to CPS for auditory dysperceptions. All this is part of a history lost during the transition from child neuropsychiatry to adult psychiatry, to which G. arrived because he was not doing well—or had begun to not do well again. Despite this, for a few months since reaching adulthood, he's been on sertraline because he says he's depressed and carries a deep-seated death wish; olanzapine, more than a mood stabilizer, for the voices he hears—described as inner imperative dialogues—controlling his self-harming agitation; zolpidem as a sleep inducer; diazepam drops for escalating anxiety and distress; and disulfiram—which we discontinued—as symptomatic drinking (which had relieved powerful afflictions like guilty anger and depression, especially during the summer break) is now controlled. The pharmacological response, in short, results from disjointed prescriptions hiding diagnostic uncertainty—and even before that, the impossibility of reconstructing Giovanni's history.

I saw G. again four days after our radiology episode. He is tired of being in a ward devoid of activity and doctors—he was admitted because he wanted to be, but now he's fed up. I can understand: typically, patients are assigned to a physician who follows them throughout their hospitalization.

Here, the same interruptions return—something G. has experienced in many domains and intrusions succeed one another, there's never anyone for him, it's always like this, never continuous.

G. rushes us through without any affective participation; he says he'll tell where the problem comes from just to conclude his hospitalization as quickly as possible. He says, "I am depressed"; the story goes back to last summer when, as a youth center animator in his vil-

lage, he became very attached to N., a nine-year-old boy he sees as a little brother, whom he carries on his shoulders, whom he holds in his arms, to whom he grew attached—an affection that only he truly knows, because he managed to feel the same feelings for siblings who were not truly his own.

N.'s mother, disturbed by the animator's morbid attachment wanting to see her son constantly, no longer wanted her child to see G.; she demanded that G. be barred from the children's summer recreation center and discredited him in that youth milieu. G. could not tolerate it. He insisted on seeing the child; he wanted N.'s mother to be informed of his hospitalization and suicide attempt—to know that she is the cause of his distress and collapse.

G. tells us he has a special friend, the reason he chose to go to the surveyors' school: a classmate. He seems to more consciously acknowledge his sexual identity struggles, despite significant difficulties regarding role identity. G. wants to see his young friend at all costs, even though we explain that his friend cannot enter the hospital ward and that it's better they not meet here, especially in a highly emotionally charged atmosphere.

A few days after his parents refused to mediate with N.'s family, he throws a tantrum and demands pharmacological intervention—"here and now".

He threatens his father if his cell phone isn't recharged—that we must fulfill his every whim, big or small, always senseless and provocative. His voice changes; his facial expression becomes mask-like—there's no access to his rage/anger. He always ends by saying they don't truly love him, that they're not his real parents and never saw themselves as such. During his hospitalization, we came to understand the inauthenticity of his voices—because he could selectively control some of them, especially those that pushed him toward hetero-aggression—they ordered him to strike his parents. The voices were inauthentic also due to the projectuality behind his self-harm gestures, the premeditated action plan driven by imperative voices, and the calm with which he spoke of these "horribly dialoguing" voices.

G. struck his father with a bar, locked his little sister—an occasional visitor to the house—in the dark, inside the home (his two sisters live with his mother in another village), to look for his kitten—driven by tender concern for the kitten entrusted to him, which he cared for diligently. The little Giovanni, whose expectations as the extraordinary firstborn turned into a sister-killing brother, ceased to be cared for by his parents—probably because they were unsupported in controlling and understanding the meaning of seemingly incomprehensible acts that, on the contrary, conceal many significant emotional needs. It is precisely behind these needs that the wound of abandonment may be reactivated and uncovered.

G.'s voice changes again when he demands N. visit him—he insists, uninterested in his interlocutor, with no concern for the other—there is no affectionate description of their bond.

He often receives visits from friends younger than him—they gather around his bed just as they did before he threw himself out the window. His mother says G. can't stay with kids his age—partly because of school: he repeated a year and has always been in a class with younger children, partly because he prefers such company. To Giulia, G. is lazy and avoids responsibility; he mocks school—he believes he will live off his father, an upholsterer and pub owner; often in the evenings, G. dines there with his dad. Since last summer, as old issues resurfaced, his father seeks to spend more time with him—almost every evening—stealing time from his new partner, as G. notes.

Giovanni later heard his roommate's sad story and understood that he could also apply for disability status for psychiatric reasons. That's what G. told his mother—a demonstration of "innate wickedness".

G. leaves the psychiatric ward a week later with a history of alcohol dependence, depressive episodes, and cluster B personality disorders. He's got an appointment at CPS and another at SERD. Disulfiram prescribed by SERD is continued, plus mood stabilizer valproate. Giovanni suggests staying longer with his father, uncertain about returning to school and even less interested in working as an upholsterer, aiding his father—an activity he considers demeaning.

At SCID, given the impossibility of contextualizing or providing examples of self-administered items, they opted for "a tendency—rather than traits—to behave in dependent, passive-aggressive, narcissistic, borderline ways".

Those who had known or simply encountered G. accepted the idea of a not yet structured personality disorder of variable expression—yet containing the risk of developing narcissistically, with poor capacity to identify with others, emotional and relational detachment. It also explains why he told us he felt little empathy with us or other hospitalized individuals, and why he never externalized it in his accounts—not even in his relations with peers—as if the other were deprived of individuality, even in his most intimate relationships.

I meet G. again in March 2003 during a second hospitalization—he comes from Internal Medicine where, hospitalized since February 28, he was discharged on March 1 with the following diagnosis: "voluntary ingestion of caustic substances in a patient with chronic psychosis under treatment"; he reportedly drank a quarter glass of bleach, as noted by my fellow resident.

A few days later, I talk with him and find in the file a note: "low capacity to describe his emotional states or motivate his choices—like a kind of failed realization of adult complex object relations". I learn that almost immediately he was offered long-term rehabilitation in a specialized center—partly because the parents were exasperated, partly because social services anticipated the parents' helplessness in a scenario where G. always wins.

That act, too, was not impulsive but premeditated—staged with his friends present in the ER, as was the defenestration—planned from the first floor before being truly performed in front of his friends and closest confidant.

I discuss this with G.: it is his sixth day of hospitalization, while awaiting direct transfer to a specialized center.

G. is fed up—he wants to go home to sort out a few things—his things.

"What things?" I ask.

"There's a friend—not little N.—but a fifteen-year-old buddy who drifted away from me, maybe because he has a girlfriend and no longer gives me his undivided attention". That's what hurts him—it's for him that he did it—to bring him back. But that's not what he got—instead, he perhaps only earned the disapproval of all his friends, who in these performances end up as spectators confirming once again they were no use to G.

It strikes me that what G doesn't tell us—and why we saturate the narratives of desperate parents with our fantasies of their personal educational failure—they drew close to G. and for G.—but he struggles to notice that.

In an explosion of rage—the only one during this hospitalization—G. throws a tray across the dining room table, shouting that his parents will never care enough for him.

G. says he had difficulties with his little sister because he believed he would have both parents just for him—but she arrived with that expectation. The real betrayal was the parents' separation—they had such a great responsibility, the promise of his happiness and that of his two other sisters—there was no need to choose only for them; there were at least three other reasons to reason differently as a family.

G. felt very alone after middle school—he began drifting from one high school to another, accumulating failures that everyone seemed to ignore. Yet he was gifted—precocious, as his mother once told us—and bright, having taught himself to read and write. He speaks elegantly, sometimes affectedly; even though he no longer reads any books and often wastes time hanging around the village square with youths, his dream is to write a book—he's already writing it—dedicate himself to volunteering, an experience he's had, encouraged by his parents through his youth center activity, which he abandoned, or something related to travel as a tour guide. He comes from a faraway country, and his Italian story in the only family he has concrete memories of began with a journey.

His parents told him of a grandmother and little sister who rocked him. The mother once told us that in his first months she continuously rocked and stimulated him—repeating the very demanding tone-affective recall to which he was accustomed during his first six months. She says he has always been a strange child—extremely capricious, authoritarian. This is how the child she describes as possessing the original quality of perfidy reveals himself.

This insertion into a new family—with different habits, sounds, noises, and smells than his familiar environment—is certainly trauma.

Even more so if even the language is different.

A child like Giovanni, who traveled in the early times of his "implicit relational memory"[4] through the trauma of abandonment, finds himself forced to integrate new relationships with his adoptive parents based on what remains of the mental representations of his place of origin—a place considered mental, ever becoming—for all adopted children, in my view even more complex. However, it is not conceivable that this work happened alone, nor that it happened toward a single direction: this work has meaning, and it is only conceivable if pursued in the same direction as the reciprocal recognition of parents and children.

The parents do not speak of what led them to the decision to adopt and then to adopt a second time—thus refusing to return to the suffering of their infertility struggle. Only the mother perhaps manages to think that at that time their marital relationship, undergoing slow wear, was already dying.

G. often found himself repeating the same experiences of abandonment—including being easily entrusted to a psychotherapist whenever the parents didn't know how to behave with him; unable to control him or provide precise responses. G. says he each time felt "offloaded", with the idea that his parents believed anything could work through psychotherapeutic intervention, with no commitment from them—almost as if psychologizing the difficult child early would solve the family's problems.

During his last hospitalization, his mother is particularly anxious about having to recount part of their pre-adoption history but in the framing of "he is not really our son". In the same vein, G. attacks his parents, saying they are not really his parents and incapable of acting like real parents.

During this hospitalization, I've managed to distance myself from his parents, who talk too much and thus cloud our perspective. Now it is time for G. to speak—maybe he recognizes us, and maybe it is easier to talk—or perhaps this could have meaning now that we have met.

He wants to distance himself from everything and everyone; his initial, passive, resigned, superficial, and merely formal acceptance of the specialized center becomes increasingly subjective and responsible.

G. says maybe he leaves nothing behind—that perhaps it's better to leave the things he must address in limbo because, in any case, they're just troubles.

He speaks of a love that is unshared but legitimate with a boy nearly his age; not the little one whose mother says "uses him for masturbatory practices".

Then G. says he confided in his father, but of his homosexuality he has no precise idea. Older boys tried to abuse him during middle school—he told his father immediately.

He also spoke right away of a first relationship with a boy his age, finding in those conversations a permissive, understanding father—though not one inclined to talk about it.

G. says he doesn't even know if he ever felt a deep, early intimate sense of gender/sexual identity—but he knows he spoke up to have a confrontation that never existed.

I recall one of the first things his father told me was about his son's homosexuality—with calm acceptance from the parents. At another point during the first hospitalization, his mother described him using the terms of manifest, ego-syntonic homosexuality—as part of a more complex structure.

G. doesn't know where to place himself, he says, partly because he never had contact with girls—though he already had experiences with boys—so he has learned from those. There was never a real sexual rapport. G. lacks a stable identity and seems to present homosexual behaviors with the overall immaturity of his personality.

Aggressive behaviors began very early, when the adoptive little sister entered the home—and to him she was the "adopted one", the same skin color, yet she felt unfamiliar/non-familial. He doesn't even remember the trip to Brazil to pick up the little one. It wasn't a νόστος, because he says he didn't learn anything more about his personal history. Indeed, the parents claim to be very open and direct—but a family prohibition on access to knowledge prevailed for a long time. If all had gone well, the two little ones would have grown up seeing themselves as siblings, says his mother—deprived of their individual stories. G. says he struggles to think of himself, of his natural parents—if they ever existed—and his Italian mother and father. He thinks a grandmother and sister existed. His biological mother, according to Giulia, was perhaps a prostitute—she doesn't deserve being mentioned; she got rid of Giovanni as soon as she could—thus disappearing from an already poor narrative filled with deceit and prejudice.

They couldn't talk about this because it might destroy their family. Now, they talk about it a little—because this "naturally bad child comes from a wicked mother", thereby excluding the responsibility of a wicked adoptive mother.

G. struggles to construct his own sense of identity—his internal objects—in a process integrating the representations and images of his adoptive parents with purely fantasized representations of his biological parents.

Moreover, it is necessary that parents participate in the construction of an internal world to which all family members born through adoption belong—a mental, imaginary place where all characters

come alive and acquire mental sense. But here the family dissolved prematurely—or perhaps never truly formed.

Precisely because the relationship for constructing mental representations is so important, it's on the mother-father-child relationship that even therapists must intervene—if asked—so that a child and adolescent can build an integrated internal world shared with parents and vice versa.

Here, fragmented therapeutic interventions highlighted disarticulation: focusing on the "Giovanni problem" rather than on how to construct a shared family history through common narrative.

If "origin is always a dynamic construction of the mind",[5] then the idea of a mental construction common to both child and adoptive parents gains force—an origin story encompassing not only the real life of the family, but also the fantasies and myths each family creates in its shared relationships and stories.

Regarding identity, Kaës[6] says: "It's a problem related to the possibility of recognizing oneself as belonging to something or someone from which one draws one's origins. Thus, the meaning of one's origin, accompanied by the environment in which one grew up and that continues to surround us with its relationships and affects, is essential for the completeness of one's identity".

Since recent years of school failures, deviant behaviors, and self-harm gestures, the parents' refusal has grown; indeed, during ward interviews, the phrase "he is not really our son" is more frequently uttered.

In some ways, Giovanni's parents did not foster a culture of reverie—allowing frustration tolerance, acquisition of a sense of time against evacuation. Ferro[7] says that humans don't have an instinct-regulating mind; that capacity forms through parents' mental reverie, transmitting a method of thinking.

One can think that it is precisely the missing recognition of his unique history that leads to destructive behavior—and results in adoptive parents rejecting their child.

Yet, with the little sister, the adoption worked.

It seems to me that in this case Giovanni was denied the opportunity to explore emotions regarding abandonment—the initial one linked to adoption and those that followed. Thus, they never began real processing of trauma—for both G. and his parents—which is necessary for creating authentic parental bonds—a true filiation.

"We spontaneously invoke the idea of trauma in adoption situations—either concerning the child or the trials preceding adoption for parents. Yet trauma can also be present for adoptive parents in the early phases of adoption. This dimension must be explored clinically because it is determinant in building parent-child bonds".[8]

G. reached a point where he didn't know who his real family was—and it threw him into crisis during important life moments, like choosing his academic path, when he found himself alone while parents considered dissolving the original family they had so wanted; when choosing gender identity; identification with a parent. For G., adolescence was an after-effect of other vulnerabilities—and again he failed to manage it. He begins to blame himself—he lost a lot of time and now doesn't know where to restart or what direction to take.

That's where the specialized center can function—he has nothing to lose, he says, and he needs someone to make decisions for him. It's paradoxical because with his parents he's capricious, stubborn, each decision seems indisputable—he doesn't accept criticism and becomes polemical and fierce, and the parents fear it because they have no control. Then he says he's ashamed when he sees another patient aggress their mother—and he remembers how he used to protest and defend himself with his own mother.

G. wonders how much this mother is truly his—and not only his adoptive sister's; in other words, a sense of real belonging between Giovanni and his parents never arose—a sense that necessarily passes through integrating trauma into the family history.

"It's the right to a history—it doesn't imply fully assuming it; one might keep only fragments, refuse it at times, idealize it at others. Then, sometimes comes a second stage: to sublimate it, use it as a creative ferment, or even forget it. But to forget this history, it must not have been forbidden, denied, or transformed into something humiliating".[9]

His natural little sister—he accepted her immediately—gradually preparing for her arrival and recognizing her as the child coming from the womb—"not a stranger because she belongs to mom". This refers to primary and mental affective ties, which in a way substitute natural birth. I don't know how G. was conceived in his adoptive parents' minds and experienced in his mother's mind—with the necessary time, without the rush of another adoption legitimizing the first—so that genuine belonging ties could form.

The hospitalization ends in the first half of March: G. will visit the specialized center where he might be accepted for a rehabilitation project "away from the family and home setting, to promote social reintegration in view of possible vocational training".

G. accepts the specialized center experience as an opportunity—defined as "a protected, high-intensity, residential rehabilitation experience". Truly, G. understands there's no place for him at home; his parents see no other solution—they think they have fulfilled their duty and must now relinquish their son, because G. now belongs to the specialized center. The local/territorial psychiatrist mediates these demands—the parents' request for absolution and de-responsibilization, and G.'s increasingly conscious desire to overcome the crisis—to find, as he says himself, a way to evolve.

I was struck by how the cold, detached, unaffectionate young man from that first hospitalization took me in his arms and said goodbye.

In sum, I was not his specialist of reference—I simply sought to assemble the pieces of his puzzle when we crossed paths in the hospital service.

The local/territorial psychiatrist calls me one morning and asks if I'm available to accompany G. to a specialized center in Varese for a preliminary insertion meeting. I first think it's an unwanted afternoon transport at a time with few CPS operators—but my colleague tells me G. had shown him a photo on his phone of his doctor—that's why it made sense that it was me to accompany him. That sign of a possible affective and mental bond, reciprocal recognition, gave me hope for the meaning of this new residential experience and for his path to adulthood.

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