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Psychological consultation as a transformative first clinical experience

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Abstract. – We propose here a model of a step in the clinical process that we consider relevant and deserving of greater consideration among practitioners. Consideration and relevance are increasing, indeed, especially in the psychoanalytic world. In view of this centrality and the plurality of theoretical-clinical models present today, we believe it is useful to offer a contribution that, taking this history into account, moves forward in the conceptualisation of this first step in each patient's clinical journey. To do this, it is necessary, in our opinion, to start by focusing on two concepts, the subject, and the care, and then to place consultation within this perimeter by giving it a specific place. While acknowledging the peculiarity of consultation when it involves certain specific age groups, childhood and adolescence in particular – groups that have given rise to some of the most innovative and well-known conceptualisations of consultation, to which we will briefly refer – this paper wishes to deal with consultation as a clinical process having a general scope. A brief exemplifying clinical vignette and a specific experience of setting up consultation in a third sector organisation will be proposed; examples which we believe help to concretise and clarify what is proposed without any claim to exhausting the complexity of possible applications.

Key words: psychological consultation, psychotherapy, psychodiagnosis, subject, relationship, child, adolescent, family, network.

"There are two ways of thinking about complexity:
one can think that the world out there is complex
and that we look at it with awareness
but believing that we are neatly
outside this complexity,
or we can think of ourselves as part of it,
inside the complexity with all of ourselves
and only with the possibility of dancing within it."
S. Manghi

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Inside the complexity of the care encounter

Focusing on the clinical device we call 'psychological consultation' makes it necessary, in our opinion, to present some preliminary remarks on at least two macro-themes: psychological care and the subject.

As regards the former, we believe it is useful to state beforehand that psychological care can be thought of as an artefact contemporary societies produce within their welfare systems. They do so in different forms in relation to different variables that characterise them: these include the value of subjectivity and discomfort, and the forms of social relationality.

Psychological care is, therefore, configured within cultural representations, norms, and economies. The specific social system organises it, however, by giving voice to an inter-human relationality that has always been present everywhere. Care characterises the human being like few other relational practices.[1] The forms it takes, however, can be very different throughout history and in different cultures.

Caring is a form of relationship that is in fact enacted in formal and informal, professional and non-professional ways. The first element that we believe should therefore be drawn attention to is that when a human being encounters a request for care, addressed to people who provide it, he or she makes this request within a specific cultural universe, and not in a vacuum.

Our civilisation, for reasons we will not go into here because we would be straying outside the limits we have set ourselves in this paper, produces professional figures who perform care functions,[2] including psychotherapists who

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1 "A student asked the anthropologist Margaret Mead what she thought was the first sign of civilisation in a culture. The student expected Mead to talk about fish hooks, earthenware pots or millstones. But she did not.
Mead said that the first sign of civilisation in an ancient culture was a broken femur which had healed. She explained that in the animal kingdom, if you break your leg, you die. You cannot run away from danger, go to the river to drink, or look for food. You are meat for predatory animals on the prowl in the vicinity. No animal survives a broken leg long enough for the bone to heal.
A broken femur that has healed is proof that someone took time to be with the one who fell, bandaged his wound, took him to a safe place and helped him to recover.
Mead said that helping someone else in difficulty is where civilisation begins. We are at our best when we serve others. That is what being civilised is all about'.
Giuseppe Melillo Huffpost, 26.3.2020

2 Even a cursory examination of recent history in this part of the world would show that we have gone from care functions limited to a few professional figures (doctors, midwives, teachers, etc.) where it was the family system (and women in particular) that took charge of most of the functions themselves, to a more recent history that has seen the emergence and affirmation of numerous figures (tutors and counsellors, psychologists and social workers, a growing number of medical specialists, etc.) who increasingly carry out their tasks within a welfare system in which they are key figures who integrate the functions of present-day families in their multiformity.

do so after a long training process that helps them to organise their presence in relation to the request for care, an approach explicitly founded on scientific knowledge translated into instruments of interpretation and intervention.

In this knowledge, it is perhaps useful to focus on the human subject, the person, since he or she is both the originator and the recipient of psychological care.

We are referring to a thinking (Minolli, 2015, Vanni, 2023, among others) that considers useful the idea of a *unitariness* and *relationality* of the human subject - the 'relational subject' - developing its becoming over time, with a beginning and an ending. From the conception of a genotype that is the bearer of a unique genetic heritage placed in an equally unique context - the maternal subject that is part of a world – a combination which forms its 'initial configuration', it realises itself in relationality until its death.

Placed within this framework, the human subject *becomes* by undergoing the experiences in which he lives, which gradually constitute more stable forms of interpretation of himself and his becoming in the world. The use of the subject's experience - explicit and, above all, implicit - as a vertex for staying in the present, can be thought of as a useful criterion for understanding his capacities but also his difficulties since, by definition, what he will encounter in his becoming will be in part different from what he has experienced before, and will gradually constitute his identity autoreflexively. Each new experience will be read in the light of how that subject has been formed over time, but will never be identical to what he or she has experienced. This dynamic between the expectation of confirmation of self and of one's criteria for reading the world and the novelty of the incoming experience, as we shall see, is a key point of the theory and, thus, of the method derived from it.

If this is, in broad strokes, the human subject, this is what he will also bring with him in his request for care. It cannot be otherwise. And if the relational organisation that is relevant for him is formed by the humans around him - his partner, his family, his training and/or work environment, etc. - it is these elements that will share his becoming - and therefore, he will share theirs - and it is this 'further configuration' that will present itself - in action and narration - on the scene of care. As we shall see, it is therefore precisely this that we need to *welcome* in the psychological consultation.

Theories and techniques are therefore buoys that we set up (as professionals and as people) to put some order in the chaos, in the awareness that disorder lives in us and pervades us, as the exergue of this work suggests, and that we are not magically outside it, but rather densely, dramatically, within it. Thus, the subject of each psychotherapist gives his or her own singular interpretation of the role that they play as social craftsmen. An interpretation that is not only cognitive, but subjective in the round. They are therefore a human subject who, over time, has acquired and, to a certain extent, integrated into his humanity, knowledge and tools, which give him

an experience of *order in disorder* (Morin, 1983). Indeed, this contribution of ours seeks to place itself on this plane. This density is present from the very first moment of the encounter and is brought into it both by the applicant and by the caregiver and, as we shall see more clearly, both by the 'requesting care system' and by the 'clinical system', since the caregiver too is not alone in the world of care, but is part of a system that we should take into account in our clinical thinking.

Some consultation models

In the history of clinical psychology, various consultation models have been put forward over the last half-century, starting with English experiences - from the Tavistock Clinic to the Brent Centre – followed by Italian ones – from Tommaso Senise to Arnaldo Novelletto – then North American ones – Finn – and we would like to briefly consider some that we feel are most significant for us.[3]

A model of consultation in childhood: 'participatory consultation' by Dina Vallino

One of the most interesting and most widely used approaches with children is that of participatory consultation. Participatory consultation is the term introduced by Dina Vallino to talk about a psychoanalytic consultation process aimed at parents and children.

It is a process that does not exclude the individual psychoanalysis of the child, but extends it, because it involves the parents in the responsibility of caring for their children prior to any further clinical course.

Two constituent elements can be highlighted in participative sessions: not only the proposal that the parents get involved, in observation as well as in shared playing in the session with the child, but also the invitation to the child to express his or her emotional contents and thoughts (Sala, 2019), *i.e.* to open up communication through drawing, playing and the telling of little stories.

Instead, in sessions where only the parents are present, the focus is on sharing what emerged during the participative sessions, with particular attention paid to the experiences of the child and the parents' ones, which gives them the opportunity to clarify the meaning, and also to be able to find, on their own account, answers concerning their child's experiences, thoughts and states of mind (Vallino, 2009).

[3] We refer to the volume 'La consultazione psicologica con l'adolescente' (Vanni, 2015) but also to 'Un breve viaggio nella propria mente' (edited by Adamo, 2000) for a more in-depth historical examination of the topic.

The main objective is to support the child so that, by using symbols and metaphors, he or she will attain a revelation of self, and this will favour the recovery of parenting skills as well as enrich the child's self-revelation.

The therapist observes and plays, together with the child and the parents, allowing himself to be permeated by the emotional atmosphere of the session, and exercising his 'negative capacity' as far as possible.[4]

The proposed way forward is to bring out and begin to unravel the tangled skein formed by the child's symptom, the 'misunderstanding' of communication, and the confusion linked to the child's discomfort and the parents' discomfort.

One of the aims of the participative consultation is to comprehend the parents' misunderstanding of their child, both in terms of communication, feelings, experiences, and in relation to the origin of the child's symptom, which can be found in the relationship with the child's needs (Vallino, 2009).

The 'Minotauro' model

From the 1980s-1990s onwards, the Milanese 'Minotauro' group developed original thinking regarding the adolescence clinic which, while referring to Franco Fornari's theoretical legacy, contains very specific elements both on a theoretical and on a clinical level (Charmet, 2000). The consultation model envisages a separate space for the child and for each parental figure, and a sharing space made up by the various clinicians seeing the family members. The basic idea can be found in giving voice to the role (maternal, paternal, fraternal, etc.) and to carry out a work of synthesis as a group of clinicians, where each clinician reports the 'voices' they have encountered. In particular, the model is connoted as an intervention on the adolescent crisis seen as a moment of intra-familiar symptomatic communication, to be treated with timeliness and intensity, and often to be concluded with a 'dramatised' restitution in choral form between the two groups - family and clinicians.

The model, which has naturally found partly specific developments in relation to certain key themes - suicide attempts, eating disorders, antisocial behaviour - remains strongly oriented towards the involvement of family figures in the signification of the crisis itself, and may envisage the use of test instruments for heuristic rather than diagnostic purposes. (For further details see Lancini, 2007).

This clinical proposal - and its developments in the so-called 'evolutionary psychotherapy' (Lancini *et al.*, 2020) – constituted an important discon-

[4] Neri, C. (2017). La consultazione partecipata. In: F. Borgogno, G. Maggioni, eds., Una mente a più voci. Sulla vita e sull'opera di Dina Vallino. Mimesis Edizioni, Milano.

tinuity in the treatment of adolescents and young adults when it was introduced and is still used today with regard to different ages and issues, including childhood and adulthood.

Open dialogue

The Finnish group headed by Jaakko Seikkula developed a model of crisis intervention in the last decades of the last century, in particular with adults presenting psychotic or behavioural emergencies, which was then extended to a wider clinical population and became widespread all over the world also thanks to parallel and thorough research work on the interventions themselves, which showed their effectiveness.

The theoretical background is predominantly systemic but influences from Infant Research and Soviet school philosophers are present (Seikkula, 2021). The intervention, which in our own words could be defined as consultation, is usually carried out at the patient's home and immediately involves the entire family and extended family context, is characterised by high intensity and prolonged timeframes, and only rarely involves the use of drugs or hospitalisation in dedicated places. The listening approach is strongly respectful of the actors present and the attempt to give voice to and bring silent instances into open dialogue is configured as the start of what will later inspire subsequent treatments involving the same family protagonists. The consultation clinical team is always supra-individual with a precise definition of internal roles that is exquisitely psychotherapeutic and aimed at producing transformative and orientative experiences based on listening and open dialogue.

Some aspects appear to be common to the three models: a focus on psychological consultation as a fundamental junction in clinical psychology, a vision that is attentive to the individual subject and to the system in which he or she lives and is made a participant in the clinical process from the beginning, the presence of aspects of technical specificity within a more general perspective that enhances the relationality of the subjects who are part of the two systems, clinical and requesting care.

In our consultation proposal, it will be easy to trace these and other cues present in the models summarised here. Let us see how we develop them on a clinical level starting from a different theoretical perspective such as the one summarised above and which we will further specify in the following pages.

Setting up the meeting

We mentioned above that when the psychotherapist receives a request for care, the theoretical thinking and technical tools he possesses are immersed in his wider humanity and sociality.

The encounter with people who express a request for care is therefore not, except in part, an encounter of words and thoughts. First of all, we think of it as *a meeting of subjects that takes place in a social context.*

Therefore, how can we set about organising and preparing this meeting? And getting ourselves ready for it...

Setting up the first meeting is usually the responsibility of the psychologist/psychotherapist and the Association he/she is a member of, with legal norms and cultural perspectives that delimit, as mentioned, the options but always leave room for his/her - the clinician's - and their - the Association's - interpretation.

On the other hand, anyone presenting a request for care does so to an interlocutor, a person and/or Association, whom he/she has an affective representation of, and expectations, albeit unsubstantiated, beforehand.

We would therefore not be indulging in an 'industrial', manualistic vision of care, but its representation as a 'scientific craft practice' (Lingiardi, 2018), where singularities are not obstacles but where seriality and repetitiveness are certainly very contained not only as a respectful tribute to the singularities of the protagonists as well as the need to favour the complexification of the request for care as the expression of the complexity of the subjects present, as we shall see better.

For the time being, we will limit ourselves to considering that there is someone presenting a request for care and someone who responds, although there are forms of consultation in which this configuration of roles is reversed, and there are contexts of care in which it is not the clinical system that sets the premises of the meeting but the patient or other actors.[5] In order to facilitate understanding, however, it is appropriate to start with the most common form, since we believe that the general model of thinking we propose does not change in the other possible forms.

If, therefore, the person presenting the request for care does so not only with words but by presenting himself, and the person who accepts this demand does the same, it is from this point that we should start to ask ourselves how to consider the meeting, and even before that, how to set it up, how to prepare both concretely and symbolically for this meeting.

If we were only interested in words, it would be sufficient to set up and proceed with efficient phone calls, but we would be missing the best part of the meeting with the other: the bodies and their reciprocal interaction in the space that is intertwined with words and the para-verbal characters that accompany and qualify them. Anyone working with children knows this particularly well, but it is to be hoped that anyone caring for the older groups should recall this and take it into account.

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[5] In the book 'Psychological Consultation with the Adolescent' (Vanni, 2015) there are some illustrative insights into these types in the adolescent world: from home consultation to Emergency Room consultation.

Let us therefore imagine that, because of the possibility that the psychotherapist has of configuring the space and time of the meeting, he can arrange to favour the matching of concrete human subjects, including himself and/or others representing the caregivers.

We find it useful, as we have pointed out, to distinguish *ab initio* between two systems, two 'relational configurations' that meet: the clinical one and the one that expresses a request for care. Consultation starts from these two 'systems', each of which can be formed by several people or, of course, by just one person in each system.

Thus, it may be that the phone call, the e-mail, the knock at the door, finds someone who answers and is not the psychotherapist - who would proceed with the second or third step, the actual clinical meeting - but a secretary, a nurse, a colleague... or it may be the psychotherapist himself. It is important, however, to recall that the consultation begins right there, at this first contact, and that it is already an initial response, an initial form of signification, an initial rebound that the request for care expresses at the moment of its formulation. It refers to 'reception', and that is no small matter among humans. It cannot be taken for granted, especially when one brings one's self, pervaded with fragility, to a meeting with a stranger who receives us in places that are familiar to him. Places and people that are, instead, unfamiliar to the patients.

Depending on the organisations, the timing, the number of requests, etc., this first meeting can take on various forms. We will examine some of them later, but this is where the consultation starts, at the first meeting of the two systems.

Usually the request for care is not formulated in presence, it is generally expressed in a phone call or through a device that ensures distance and a dual dialectic. This forms part of the current constraints of technology, and not only. The caller, however, does not necessarily express the request for himself, or only for himself. He often does so 'on behalf of', or 'with' someone. We would therefore consider it reductive to delve too deeply into that dual moment at a distance since it could artificially dualise a possible and potentially rich multiplicity. With children and adolescents, this is actually the norm, but it could also be the case later on in the developmental trajectory, if we are the first to give space to this possibility.

Our wish and expedient approach is therefore to invite those who feel the need, to express their request for care in presence as soon as possible, together with anyone who feels involved in that request. 'Anyone who needs to may come' is the succinct expression that may be expressed at the conclusion of the call.[6]

[6] This clinical perspective can of course be integrated, and it is possible to do so in many ways, with existing legal norms that are, as always, expressive of a culture in which clinician and patient coexist.

This move may seem risky and, above all, uncertain. Who will come on Monday at 4pm? Maria? Will she be with her son? Or will she come with her husband? And the grandmother who is at home caring for the little one during the day?

We believe we should avoid asking questions on the phone about who it is relevant to invite, given the unreliability of the results, due banally to the clinician's lack of knowledge of his interlocutor, and so we might as well take seriously the fact that up to that moment, and even afterwards, the person who has turned to us with their request knows better than we do what questions to put forward, and who can best interpret them. To do otherwise, if we were to choose, would result in arbitrary randomness on the part of the respondent, however experienced and attentive he may be.

One then gradually allocates those present at the session, and requests other presences. To accept a request means initiating a process that can start in many ways, the important thing is that it should start in the most useful of ways.

Since the consultation is not a photograph, but a film, and we have indicated above when it begins and we will say when it ends, knowing that it involves a meeting, or a series of meetings, at a place and with times that will be negotiated between the two systems.

Different actors may be involved in different interviews, or even within the same interview. We can ask a child's parents to leave the room for a moment so that we can talk to the child alone, or we can ask the dad who arrived late to come in and participate in the meeting, or to wait a moment in the waiting room. But this will be done in compliance with the situation that emerges based on the evolving relationships.

The psychotherapist/clinical system will, however, need prior notification concerning the setting up of the place where the meeting will take place, as well as the proposed space-time of the meeting: a decision will be taken as to whether the psychologist will be alone in welcoming the guests or not, and a proposal will be made as to whom to invite, from the clinical system, to take part in the meeting and when, with whom, and for what purpose.[7] This starting option should, of course, be communicated to the person who makes the phone call, and it is an important element in setting up the meeting we are discussing.

[7] In the absence of information on who will be present at the first meeting, and for reasons also linked to the need to provide a competent figure as director of the consultation, who will therefore keep the threads unravelling, some of us prefer to propose that the first meeting be attended by a single clinician who can draw on other options as the need arises, but of course other choices are also possible, which, moreover, also relate to the subjective preferences and idiosyncrasies of the clinicians themselves.

What is the purpose of consultation?

At this point we should ask ourselves an important question. What is the purpose of the consultation in the light of the theoretical thinking we started out with?

The consultation has two objectives: to co-construct a form of care that is useful for the person requesting it and possible for both systems - an 'orientation' objective - and to provide a sample of a possible care experience - an 'experiential or transformative' objective.

Sometimes a sample tasting may be sufficient, but more often it stimulates the appetite. This is also the case with consultation. It is rare, but it does happen, that a few meetings will expend the need for care, and there are situations where - either because of the significance of the meetings in relation to the quality of the needs, or because of the difficulty of moving forward together - no follow-up is required, or perhaps not with that professional or with that clinical system, or at that time.

In most cases, however, the care needs remain intertwined with those provided by the caregivers, introducing a pathway that develops over time.

It is our belief that the guiding purpose of the consultation is to jointly identify the best possible way to continue the care process.[8] This is where the consultation ends, and the next therapeutic pathway is initiated, with the same or other actors.

We have often used the prefix 'co' or 'con' – already present, and not by chance, in the word 'consultation' - and we believe it is useful to spend a few words on the importance of this prefix.

If we have respect and consideration for the subject, we evidently cannot treat him or her as an object, as a thing that is learned, and 'about' which one can voice an opinion in terms of diagnosis - we will discuss this shortly - and of therapeutic indications. The clinician does not know the patient[9] or the configuration of persons who present themselves to him, and will not know them fully even at the end of the longest and most accurate psychotherapeutic journey. He will have a representation of them that will be enriched and complexified over time, but this cannot justify decisions 'about' him or 'about' them.

If we have respect and consideration for the subject, it is evident that we cannot treat them as an object, as something that we learn about and 'about' whom we express a view in terms of diagnosis - we will discuss this later -

8 We will see in a later section in which general idea of care our proposal fits.

9 Michele Minolli (personal communication) used to say to patients, or sometimes said to himself, in early meetings, a phrase that we want to recall here: 'I have read many books and have a lot of experience but I know nothing about you'. A dutifully respectful position in the meeting with the other.

and of therapeutic indications. The clinician does not know the patient[10] or the configuration of persons who are present, nor will he know them fully even at the end of the longest and most accurate psychotherapeutic journey. He will have a representation of them that will be enriched and complexified over time, but this cannot justify taking decisions 'about' him or 'about' them.

Does this mean that he should refrain from proposing, or shy away from proposals that come from the patient's system? Not at all. It would be disrespectful both to the clinician and his system and to the knowledge that resides in it, and to the patient himself. And there lies the meaning of co-construction. A negotiation process that respectfully brings into play the options and idiosyncrasies of which the two systems are bearers as living systems.

The forms the subjects use to place themselves in the consultation relationship constitute their way of being together, and allow us to observe and experience how they are configured in the relationship between the two systems in that specific space and time. At the becoming of the consultation interaction, all participants will experience a partly new relationship to which they will inevitably and appropriately bring their experience of life, be it short or long, and that will also be the case for us clinicians, of course.

There is a widespread belief that the initial clinical meetings serve to assess the other, i.e. there is a way of thinking about consultation, which in this case takes on different names - assessment, evaluation, etc. – and which sees it as focusing on the object, the patient – the individual or the family.

We cannot disregard the value of this approach, in which attention is given to the person who presents the request for care, but we believe that it needs to be integrated with three other aspects: the plurality of subjects at times constituting the system that presents a request for care - a family for example -, the part of signification that the clinical system performs, and the specificity and singularity of the meeting of those two systems *in that context*. We shall spend a few words on the latter aspects. In the following paragraphs, we will say something about the former.

We should not underestimate that the first meeting is such also for us, and therefore the references we have built up over time in our personal and professional lives are challenged each time by the singularity of the person we meet and of course this cannot be scotomised but, on the contrary, it is the object of specific attention because it is the starting point of our experience of the other, of *that* other, which will then evolve over time.

Furthermore, our interlocutor(s) will engage with us within the meaning they give to that request for care and, therefore, to the system towards which

[10] It seems to us that this is also the case in the medical sphere, and there is nothing strange about this because we are talking as a unit about a subject whose biological part functions on the basis of general principles that also apply to the 'mental' part, to use this now obsolete dualistic distinction.

they have addressed this request. It is true, therefore, that in this, too, they will express their way of being, but we must be careful to place this information within that specific relationship and not treat the care context as a neutral, observational place because neutrality is simply not there. If that person or that family were encountered in a research context or in a hospital or at home, they would show partly different aspects in relation to what that meeting means.

From another perspective, and using a more traditional language, we can draw attention to the relational aspects of the meeting, and to the central role of the transference/countertransference dynamic, conceived as a deep-rooted weaving of the process between the care system and the patient's system with all the dual and supra-dual weavings often present, as mentioned earlier, a dynamic that is also present from the outset in the weaving of the consultative meetings.

Subjects and systems that meet

We need to present a further theoretical explanation here by adding something to what has already been mentioned: the request for care, we think, is a 'request for confirmation', which also implicitly contains an 'expectation of disconfirmation'. Let us try to explain this better. Our position in the world will always be the result of how we have arrived where we are, applied at all times to an experience that will always be new and old to some extent. By definition, it will therefore always be an opportunity for confirmation and disconfirmation of what we are because we are constituted precisely by the self-definition of what we have learned to be. Our identity. If a subject feels that he is well, he will not formulate a request for psychological help, but also in his other relationships at that or other times in his life, he will tend to read his present experience in the light of what he has learnt from his history, and if he feels that this 'works', if he does not perceive unbridgeable discrepancies, what he will experience - and there will always be discrepancies, as we have pointed out - will be stimuli that he will know how to take into account in order to broaden his experiential complexity and his identity. Meetings with small or large disconfirmations will constitute a continuous urge to revise one's idea of oneself and the world. As far as the initial part of this binomial is concerned, this will constitute what one of the authors has called elsewhere 'self-learning' (Vanni, 2023).

If he formulates a request for care, he will be the bearer of experiences of discontinuity that he is unable to integrate into his identity, *i.e.* into his 'definition of self'. This is typically the symptom.[11]

[11] It seems to us that this is also the case in the medical sphere, and there is nothing strange about this because we are talking as a unit about a subject whose biological part functions according to general principles that also apply to the 'mental' part, to use this now obsolete dualistic distinction.

What he brings to the scene of the care is, therefore, this wound, this failure, this expectation of confirmation/disconfirmation, which, however, contains information which is very useful for us.

Obviously, each subject who presents himself at the scene of care, if and how we allow him to do so, if and how we favour or hinder him in this, will be the bearer of this perspective and what happens in the consultation is the transfer of this perspective into the meeting with the clinical system.

If we take an individual, a person, he will bring, he will tend to implement on the clinical scene his way of being and this is exactly the object of psychological diagnosis, as we will see shortly.

In the case of children or adolescents, for instance, we are often faced with parents who bring their 'broken child' to the consultation: a child or adolescent who needs to be fixed, and in that case, the purpose of the consultation also becomes the 'signification' of that experience of rupture within the family functioning.

The child's or adolescent's discomfort may be a symptom of an uneasiness that goes far beyond the subject himself and may be the expression of the child's identification with unconscious, painful, traumatised and never processed aspects of the parents. In a way, it is as if parents sometimes ask us to be healed through their children.

The weaving of these dynamics highlights the differences present in the ways of being within a family or a couple who present a request for care, and the therapeutic paths that will be the outcome of the consultation can therefore be very varied. These weavings have so far been balanced and that balance is now brought to the consultation meeting where it will receive a stimulus. This is our responsibility.

However, it is worth emphasising that the therapist and the clinical system as a whole are affected by this quality of demand. Even the professionals who make up the clinical system are in fact subjects with a personal history which, as we pointed out in the first part of this paper, has been enriched and integrated with knowledge and training experiences; it survives and urges to find in therapy as in life occasions for confirmation, even with that patient, even with that family, even with that couple. Thus, what the encounter with those patients produces in the clinician and in his or her system, will become very interesting not because it is introduced to him/her by the patient, but because it is a personal experiential reflection of what that patient/family/couple produces in him/her as a clinician. It, therefore, becomes very enriching to be able to pause on these lived stimuli right from the consultation because right from the consultation, the density of the internal world of the relational configuration that shares that space-time with us will ask us for complementarity and, therefore, confirmation/disconfirmation.

Being present to this feeling means a lot and will help us form a relationship that is also possible for us and implement useful therapeutic options.

Psychodiagnosis: an ugly word?[12]

Forming an idea of what we experience is one of the ways that humans put into practice to find order in the chaos of uncertainty. They do this all the time and they also do it in their clinical activity when they are caring professionals. Psychological diagnosis is simply the organisation of this attitude. It is guided by knowledge, by theories, and produced by means of techniques that are sometimes very refined and specific. In many cases they are aimed at placing that specific subject within a population range with regard to certain parameters (e.g. learning or anxiety). Although we understand the social usefulness of this form of diagnosis, it is not to be placed at the centre of the idea of consultation that we propose, since what interests us is to accompany the subject to a contact with his or her specific way of being at that moment, and therefore we are interested in singularity and not its relationship with the general population. This singularity, however, also requires thinking, since it is also on the basis of the thinking - a thinking that feeds on and integrates emotions and actions - that we will construct that subject and we will be able to compare him with himself. The 'diagnostic' tools we will be most interested in, or if you like, the use we will preferentially make of diagnostic tools - in a broad sense, from interviews to tests, to the use of play materials, etc. - will thus be oriented by their 'heuristic' function, that is, by the capacity they have to facilitate self-expression and an approach to the self [13]on our part and on the part of the subject in the room with us.

Diagnosis is, therefore, the progressive focus of a subject's way of being within a caring relationship and the premise and object of the future caring relationship itself. This 'way of being', in its most stable form over time, is expressed by psychologists with the word 'personality' and thus personality styles are to be understood as macro-categories that contain the specific forms of that singular subject in the becoming of the relational experience.

More or less stable subjective configurations

If we widen the field to include the familiar or the proximal world of our subject in care (the couple's relationship or the one with one's best friend or mother for example), we will see that in these relationships a complementarity of subjective configurations takes place. The other, we speculate, suf-

[12] The phrase alludes to a famous expression by Nancy Mc Williams (1994).

[13] As we mentioned earlier, psychological consultation also has an experiential and therefore a transformative objective, albeit in the restrained form of a taster.

ficiently confirms our way of being. It can never be completely so, it would not be a relationship between living beings, but if it were too little we would feel much more threatened than confirmed, or perhaps simply indifferent, and, we believe, we would hardly maintain that relationship. Those who grow up within subjectively important relationships (children, adolescents...) will pursue a continuous learning operation to actively place what they gradually become within that family context and then school, friendship, etc. contexts.

Thus, what a family brings to the scene of care is precisely this balance of forms of different ways of being to which each person brings his or her own experience of being there, and what each person will tend to do is implement his or her own affective culture that, if they are with us, presents some discontinuity that he or she feels is not easily integrated.

It therefore becomes important and useful to give the subject(s) seeking care a further opportunity among those that life has offered them to get in touch with and relocate the experience by recomposing the fractures, reconnecting the discontinuities, reuniting the internal alterities in a form which is different to what was historically acquired.

Here we should add another theoretical piece which once again concerns the theory of the subject and, to some extent, the ethics of care. Our function as therapists is not to restore a functioning closer to the norm (statistical or social), nor to facilitate an adjustment to the demands of the context (social, school, family), but to provide an opportunity for a better self-presence of the subject(s) in our care. We could say that whatever configuration of personality, whatever form the subject has taken on to be in the world deserves respect because it is his, it is what he has succeeded in doing best, and if he is there we can, if he wishes, help him to come to terms with a different outlook that puts him better in touch with what he experiences in his life that, at this moment, constitutes a discontinuity that he cannot manage, digest, integrate. It is this discontinuity - what we read in the experience we live - that today in part seems to be failing and we are unable to evolve because we are anchored to our historical identity; this creates problems for us and leads us to consultation. And it is the consultation that is the start, the taster, the moving towards a better quality of presence to oneself that can be pursued later in therapy and in life.

It goes without saying that this non-regulatory view also applies to family configurations, couple configurations, etc., otherwise we would be bringing into care a social orthopaedics and not an application for freedom.

Thus today provides a new and unique opportunity, and we, as a clinical system, are part of this opportunity with the function of observer/returner of what the subject or supra-subjective configuration brings into play with us as representative of what is/are in his/her/their world.

It is easy to understand, on the basis of what has been reported so far,

that what the subjects, whether individuals or within a relational configuration, bring to the scene of the psychological consultation is quite unpredictable before the meeting, and will be further articulated as the meetings proceed, but it will provide us, and provide them, with material to perceive and propose experiences and thoughts about the way of being of the subjects who are there with us, and about the complementarities and discontinuities between them.

What happens when we place ourselves in this form of listening, is that each of the actors in the field will be inclined towards the care they are getting a taster of. Therapists included.

Another principle that has inspired us and which we propose is that no one who asks for care should be excluded. It is a matter of identifying, together, how to respond to that request, not of choosing who is in need and who is not. Again, that would be presumptuous and disrespectful.

The outcome of the consultation is just that. It is to jointly identify the forms that are possible and useful for the different actors on the scene, to start along their own paths of self-presence. Including the clinical system, which is not omnipotently endowed with all skills, but which may have the opportunity to offer suggestions concerning others which are available in the wider system of which it is a part. The awareness that we are part of a welfare system which is itself part of a social system, and a culture, will guide us towards building in advance and maintaining collaborative relationships even outside the clinical system to which we belong, and which, for the aims of the specific situation - that patient, that family - we coordinate.

If we go back to the psychological diagnosis, what we propose is thinking that the sectorial and specific diagnostic focuses - the psychological ones relating to functions such as learning or anxiety, but also the medical ones relating to aspects of corporeity such as illness or disability - should be placed within a representation of the 'relational subject', who constitutes the central focus of the consultation and who, in many cases, is present in the psychological consultation itself together with other mutually significant subjects, who bring and propose in the here and now of the encounter with that clinical system their forms of existing, thus providing us with material that is as rich and valuable to understand as it is delicate to treat.

Criteria for the proposal of a therapeutic set-up: feasibility

But what further criteria can we turn to, to think about the subsequent care arrangements to be proposed to our patients? The question is important and loaded. It is a question that guides us, often in implicit forms, in our proposal and that should deserve a better explanation, one that we shall try to present here. The work with children and adolescents and their families,

perhaps more than anything else, helps us to consider one variable as central, that is to say, 'feasibility'. We could say, on the one hand, that the subject is the bearer of a feasibility to profitably take care of himself or, on the other, that this possibility is absent or untraceable at that moment of his life and in his relationship with us. The subject's autonomy is evidently a key issue: when the other is so relevant in the patient's daily life, as is usually the case, for instance, with children versus parents, it clearly appears that the space of psychological feasibility that the child can exert is reduced, and this recommends a co-participation in the therapeutic process - in various possible forms - of those persons that are so decisive.

Of course, this relevance also relates to the very possibility of participating in a therapeutic process which, if not shared by the reference persons, might not be feasible or even presentable, even as a request for treatment - unless expressed in symptomatic forms, naturally.

This criterion, which is evident in childhood and adolescence, is actually present also later on if we think of the feasibility of introducing a third party with therapeutic functions, within a couple or a family, in whatever form this takes place, and of the phantasmatic relevance of this third party in the relational dynamics. It is therefore not a matter of a concrete but a psychological dependence that welds and stabilises the existing by turning the third party into a threat, rather than an opportunity.

In the consultation, therefore, it will be necessary to explore the possibilities of developing the therapeutic pathway in one direction rather than another, to reach an outcome that is possible for the clinical system and its interlocutors, and that may not coincide with the arrangement wished for by the clinicians themselves but possible instead, at the moment, for the patients or for some of them.

Consultation with children and adolescents: some specific aspects

We need to clearly specify certain aspects of the consultation process involving children and adolescents, which includes at least one major theme: a child presupposes an adult who gave birth to him or her (Badoni, 2013): the child needs the presence of parents not only to provide the security of living, but as a guarantee of growth and mental development.

From this concept, further evidence emerges: given the incompleteness[14] of the child, working with him assumes that the therapist's mind harbours a

[14] The living subject is always unfinished but here reference is made to a form of child-caregiver bonding that appears particularly radical and is also referred to in ethological literature as 'neoteny' (Bolk, 1926).

group dimension: these are not just ghosts, but real presences, with a powerful impact on the child's mental development.

A key aspect of the consultation involving a child is therefore the consideration of the parents' ability to tolerate the intervention itself with the child, as mentioned above.

How can we enter the 'family home', we, other adults, without intruding, without judging, and also without being considered merely as guests?

The indispensable role of the adult, of the parents, is strongly emphasised throughout Vallino's work, for example: 'Not only can we not deny that the family and the environment have an influence on the healthy and pathological development of the child, but neither can we idealise the transformations that a child can make with the help of the therapist alone' (Vallino, 2013).

The child's mental development is therefore a function of the relational matrix: one of the consequences is that the position of the parents and the child's life context acquire a particular relevance within the consultation pathway. This does not imply that the only possible intervention involves shared parent-child sessions, or, even less, that no individual sessions should be pursued for the child: it implies that working with and through the significant figures in the child's life context is essential.

What has been said can to a large extent also be carried over into consultation with adolescents, naturally, but it takes on a particular pervasiveness in childhood.

A brief clinical example: family A

Beppe and Carla are spouses both working in the world of care and education, and present their request - it is Beppe who telephones the Progetto Sum Counselling Centre - explaining that they are parents of two children, aged thirteen and fourteen (Dario and Franco) and a seven-year-old girl, Giada, and that one of the two boys, Dario, is not well and is creating problems at home.

The psychotherapist Hans receives the telephone call, presents the request to the team, and it is accepted by another psychotherapist, Italo. Italo then phones the father and proposes an appointment with whoever the latter sees fit to meet.

Beppe and Carla arrive with their son Dario and introduce themselves; they complain about his behaviour at home, his unwillingness to help with household chores, his untidy room, and the difficulties he was having at the start of the school year in the new secondary school he was attending. The parents report that they then quickly transferred him to another school, the one attended by his elder brother, where things are going well.

The issue immediately appears distinctive to the clinician, Italo, both because the school problem appears to have been solved, and because the problems concerning household chores appear as truly physiological in adolescence, especially in the eyes of two 'insider' parents, both of whom are attentive and capable on an educational level. Italo makes space for dialogue with Dario, but no particular problems are identified except to confirm a period of conflict between the parents, and which Dario himself appears to be sorry for. Towards the end of the first interview, when the parents are back in the room and the clinician Italo, who has an open attitude, asks them some questions, dad Beppe reports that there was a critical phase in his personal life, about a year ago, linked to issues he was facing at that time, which he dealt with through individual psychotherapy, which was concluded, and with medication, and that this led to some family discomfort. The therapist proposes an open scenario for the next interview, which includes the opportunity to introduce the other two children in the consultation, but also to think about a single space for the two spouses. The decision is made to include the whole family at the next meeting; there, it emerges that there is continuing difficulty between the spouses in managing the children and supporting each other in their life vicissitudes – Beppe in his crisis, Carla in the daily management of a complex family life.

Dario's critical issues are also shared in part by his brother Franco, and it is reported that Giada started primary school with some difficulty and that the teachers have suggested to the parents that it would be appropriate to proceed with a specialised assessment on aspects of learning and attention.

In the individual interviews with Beppe and Carla, what emerges is a difficulty and uneasiness that has been affecting the couple's relationship for some time, but which has become more acute since Beppe's crisis, both on the relational level and in terms of the educational function; for Beppe, it is a feeling of not being understood or supported; for Carla, it is a feeling of having been 'betrayed' by her husband's crisis, which has appeared like a thunderbolt for her, the loss of a stable reference point.

After this process and upon the spouses' reappearance jointly in session, the need to examine this dual aspect more deeply emerged clearly in parallel with the removal of filial criticalities.

Italo refers the situation to the team and suggests a psychotherapy course for couples; this is accepted by a colleague, Laura, and is proposed to Mr and Mrs A, who approve of it and it has been an ongoing course for several months now.

Giada is waiting for an appointment with the Child and Adolescent Neuropsychiatry services of the local ASL (local health unit).

However, the situation proposed, albeit concisely and with utmost respect for the privacy of those concerned, clearly highlights several aspects: the request for care has been made by bringing a child's problem to the fore, and

the consultation leads to an outcome that involves the parental couple. The process, which lasted a total of seven meetings over a couple of months, allowed activation of the participatory presence of all the components, each one signifying their own actions and those of the others, and thus the consultative framework allowed everyone to remain within a common process, but with specific forms negotiated for each individual. The therapist gradually brought into focus both the forms of psychological functioning of each person - at different levels of understanding and the required thoroughness - and the reciprocal complementarities/discontinuities, favouring the emergence of a direction of care that started with what was most relevant and feasible for them: the conjugal theme that they had not been able to bring forward in the first instance. For Italo, the team constituted both the place where he listened to the presentation of the request for care, and the place where he participated in the evolution of the process and, finally, the place where the proposed outcome of the consultation was shared, as well as its operative outcome, with the other therapist, Laura, belonging to the same clinical system, and this favoured the compliance of the couple, who felt welcomed and cared for by a psychotherapist - and previously listened to on the phone by another; they then felt they could rely on a third party, who was part of the clinical system and with whom they had now become familiar, who was trustworthy and who responded to their now clearly identified care needs as a couple.

We might add, for the sake of completeness but also to highlight its importance, that this situation was brought forward by Italo, in the intermediate phase of the consultation, in an interview group of psychotherapists who deal with children, adolescents and families, and proved to be extremely useful for focusing on the forms of Italo's presence to himself and in his clinical work.

The consultative process and consultation as a permanent posture

We are now in a better position to understand the consultative process that follows the telephone call, and the start of the in-presence process because the reciprocal positioning of the actors in the field, belonging to the two systems, will lead them to actions that, as far as the clinical system is concerned, will be inspired by the needs we have described, which are to explore experiences that favour forms of approach, of contact with the self.

If, therefore, the position we suggest *ab initio* is one of open acceptance to whoever wishes to be present on the scene of psychological care, and however they wish to do so, as the meetings proceed, but even during the first meeting, the clinician and his or her system can propose and indicate actions of various kinds, thus becoming more active, so to say, on the basis of what they will gradually understand-feel is happening.

Consultation is thus configured as a space-time of an exploratory nature that introduces entirely provisional relational arrangements – a listening space for an adolescent, a meeting with the parental couple and/or with each of them, perhaps even with the school class coordinator – providing us and the persons in our care with relational experiences and restitutive glances within that arrangement, but also providing glimpses of possible future more stable configurations.

We are, of course, describing highly complex situations, but the possibility of accommodating an individual subject who brings with him a need for care, is well present in the consultation, and where the forms of the therapeutic pathway that are negotiated in the consultation concern aspects of the setting, such as the frequency of the meetings, the timetable, the fee, and little else, issues that are nonetheless present even in the most complex consultations, of course. In adulthood, these kinds of requests for treatment are very frequent and naturally may not require any extension to include other actors in the field, beyond the therapeutic couple, and at times moments of intervision or supervision involving the therapist.

However, we should point out that consultation, in addition to being the name we give to the initial phase of the care encounter - as it has thus far been presented - is also a perspective, a posture, which can and, in our opinion, should accompany the clinical system, even in the course of subsequent care, since the needs that the subject or systems in care will bring over time may evolve, and evolutions even of the forms of treatment may be recommended.

Having agreed on a specific care and setting following the consultation, it is then possible to deal with the need to introduce changes based on a shared contractuality and its meaning for all participants involved in the process, and thus to assess what to do while keeping in mind the meaning and value of what was previously agreed upon. Nothing is therefore unchanging or permanent, but everything, in psychotherapy, is to be produced in the light of a shared history. Not so in consultation where, instead, the choice of actors, times, forms is characterised by reversibility and explicit experimentation.

The team as network

While it is important to safeguard the privacy of the dual relationship, both in the consultation and in the subsequent individual psychotherapeutic treatment, I believe it is useful to consider the importance of a group of colleagues - I use the expression in a broad sense here - with whom one can share both the treatment pathway - I am thinking here of supervision, interviews, team discussions - and any needs for circumscribed counselling or the broadening or redirection of the therapeutic pathway.

The individual adult patient also feels and sees if the therapist is inside a system, and how he feels there. He often sees it also from the configuration of the place, from the website, from the snatches of sentences he overhears in the corridors spoken by the colleagues, and once again the microsocial dimension appears, not as an extraneous presence in the dual and private care pathway. This certainly does not mean supporting the indiscriminate sharing of thoughts about patients within the team. Privacy is important for the patient, just as it is for the therapist. The team can therefore be a relatively mute and deaf presence, but can become a speaking presence if needed.

This obviously requires prior attention paid to the care systems, which we will not dwell on but which cannot be improvised. Instead, it needs to be planned and maintained over time as an integral part of the clinical system and an indispensable element of its quality.

Training in clinical psychology and psychotherapy

The most widespread forms of psychotherapy training curricula within specialisation schools do not seem to give due importance to the considerations expressed so far. Usually, the training proposed concerns a therapeutic set-up – individual, family, group – at times a few of these, as well as spaces devoted to diagnostics – often understood in an experimental sense – but very little space is devoted to what comes first, and which is the first question the neo-therapist needs to answer: which set-up of treatment would be more suitable for this person/these persons facing me? Who will be able to start, and who, on the other hand, can do other things well? But above all, on the basis of which criteria and through which processes can we formulate an answer to these questions? Of course, in the worst-case scenario, these questions will not even be asked, and one will simply go ahead with that patient with what one is able or inclined to do; fortunately, however, this is increasingly not the case and therefore, there is a need to develop one's skills both with other therapeutic frameworks and to question oneself regarding the criteria and processes of reading the request for care and orientation that are the focus of psychological consultation in the sense we are applying here.

This *vulnus*, of course, is decidedly less present or sometimes absent in the specialisation schools that have as their clinical target children, adolescents or serious situations in adulthood, where the clinic has for some time now identified the need to organise care responses that include more than one subject, as has been described in this paper; but it seems to us that even in these cases, the thinking on the criteria to guide the co-construction of the care set-up, is not always sufficiently developed or made explicit. In a few clinical contexts, for instance in the consultation, one is in the presence of professional stereo-

types that guide the action and are only very laboriously challenged. It is evident that this factor has an important effect on phenomena such as therapeutic shopping, or drop-outs in the early phase of intervention.

Instead, it would be really important for clinical training to find an adequate space for the focus of the thinking and technical instruments, involving the part of the care process that goes from the arrival of the request for treatment, to the definition, perhaps provisional but nevertheless more stable, of the therapeutic process. That is, to the 'psychological consultation'. This greater relevance should be present in both pre-graduate and specialist training, as well as in the supervision and intervision work that accompanies our clinical work for a long time, we might even say forever.

An example of the organisation of the psychological clinic: reception and consultation in 'Project Sum'

In the clinical examples proposed earlier, an organisational subject, Progetto Sum ETS, emerged, which serves as a container for the clinical activity of one of the authors of this paper, and which can be illustrated better here since it constitutes one of the possible operational instances of the proposed model; of course, it is not the only one and not necessarily the best one, but it is useful to sum up concretely what we have set out so far on the level of the organisation of the clinical system in a more general and abstract manner.

In its Counselling Centre in Parma,[15] Progetto Sum, has an access organisation that provides for a good number of its psychotherapists (at the moment the group operating in the same location is made up of fourteen people: eleven psychologist-psychotherapists and three medical psychotherapists, one of whom is a psychiatrist and one an NPIA)[16] to manage a twelve-hour mobile phone service from Monday to Friday and on Saturday mornings. When answering the call, the psychotherapist accepts the request, and collects a number of clinical and organisational details, (including time availability, information on the fees, etc.), which he or she reports to the Friday morning team. The group discusses the information and, where possible, a clinician accepts the consultation, which he or she will direct.

[15] Already evident in the choice of name, 'Counselling Centre', is the consistency between the container and the content, *i.e.,* the thought and practice in a place where *care* relations take place under the auspices of horizontal co-participation - between professionals - and vertical - between professionals/organisation and subjects/patients - which makes the universality of the recipients of care - and therefore the removal of barriers to accessibility - with fees commensurate with the patients' ability to pay.

[16] Participant in the team but operating externally.

The additional places for interpersonal sharing are set up, in addition to the informal places - the lounge and the corridors, for instance - by the weekly team itself, where the discussion of ongoing situations take place, or reorientation after the consultation - as happened in the case of family A, or the BAF (Children-Adolescents-Families) interview group, which is partly made up of colleagues working externally to Sum, or a monthly online interview group with other colleagues from the Sumus network - the network which includes other cities which host Sum Project consultancies (Reggio Emilia, Turin, Pavia, Lecco, Cuneo, Fidenza-Salsomaggio Terme-Collecchio), or the Extra Large team, which once a month adds colleagues to our team - mostly psychotherapists but also some psychiatrists, gynaecologists, family mediators, nutritionists - who operate in their own offices in Parma but under the ethical conditions of Progetto Sum, and who are the recipients of the situations which, due to clinical skills and/or the unavailability of the indoor group, are sent to them after presentation and discussion in the team.

Sometimes it also happens that the recipients are colleagues of the Network for Social Psychotherapy who, in the Parma area, offer clinical activities under the banner of sustainable quality as Project Sum, albeit with some theoretical-clinical, organisational and economic differences.

The consultation process thus develops in the forms that we have shared here in a logic that enhances the singularity of the encounter between therapist-patient (or 'requesting-care system-clinical system') within a specular organisation-context of life in which we are immersed, to return to Sergio Manghi's exergue, we as subjects in this world, with the different functions we perform in it.

Clearly, the theoretical-clinical vision we have tried to elucidate in this paper finds its operational declination in organisational forms consistent with it, which therefore, to quote the major references, considers subjects in a unitary, relational manner, located in specific places and times, which it affects and by which it is affected.

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