Ricerca Psicoanalitica | pISSN 1827-4625 | Year XXXV, n. 3, 2024
doi:10.4081/rp.2024.955

Comment

Linda Alfieri,* *Mariacarmela Abbruzzese*,** *Enrico Vincenti****

Abstract. – The article *Psychological consultation as a transformative first clinical experience* by Fabio Vanni and Silvia Bertoli explores the importance of the psychological consultation as an initial encounter between therapist and patient, unique and personalised with transformative potential. The authors pose crucial questions on how to welcome the individual's singularity, the suffering they bring and, at the same time, articulate a personalised and relational rather than protocol-based treatment proposal. The importance of the mutual presence of those involved is emphasised and how this can lead to a co-construction of care strategies. The consultation is not only an opportunity for the suffering individual, but also a moment of reflection for the therapist, leading to a shared and personalised experience. While appreciating the effort and originality of the two authors' proposal, one wonders whether and to what extent considering consultation as a transformative experience, puts the relationship at the centre, obscuring and losing sight of the subject and the possibility he/she has of accepting his/her suffering as a specific element of the life process and as an opportunity to be present to him/herself.

Key words: consultation, interaction, subject, presence.

Non-commercial use only

The article "Psychological consultation as a transformative first clinical experience" by Fabio Vanni and Silvia Bertoli, which we shall be commenting on, undoubtedly provides food for thought on issues that have constant-

*Psychologist, Psychotherapist, Psychoanalyst SIPRe-IFPS; Founding member of the Group and Family Perspective Area; Member of 'IL PRUNO Centro Studi Famiglia e Gruppo'; Lecturer in Clinical Practice at the School of Specialisation in Psychoanalysis of Relationships (SIPRe), Italy. E-mail: linda.alf@gmail.com

**Psychologist, Psychotherapist, Psychoanalyst SIPRe-IFPS; Founding member of the Group and Family Perspective Area; Member of 'IL PRUNO Centro Studi Famiglia e Gruppo'; Lecturer in Clinical Practice at the School of Specialisation in Psychoanalysis of Relationships (SIPRe), Italy. E-mail: abbruzzesemaric@gmail.com

***Psychologist, Psychotherapist, Psychoanalyst, SIPRe-IFPS Supervisor; Supervisor in Group and Family Relationship Psychoanalysis. Member of 'IL PRUNO Centro Studi Famiglia e Gruppo'; Lecturer in Clinical Psychoanalysis at the Specialisation in Psychoanalysis of Relationships (SIPRe), Italy. E-mail: evince57@gmail.com

ly been considered regarding therapy and our meetings with individual patients.

How do I welcome that individual who is knocking at my door? How do I articulate a care proposal to examine that specific individual and the specific question he is addressing me? How do I process my knowledge and the specializations I have during our meeting? Will they provide the right solutions to his requests? What does a form of care that sees the individual becoming part of the relationship, and at the same time the relationship becoming one of the main tools of the work being done, look like today? But also, is all this still relevant and responsive to the needs of suffering?

It is for these reasons that we find the article's proposals truly stimulating. They are striking thanks to the clarity with which they describe the *very complex* interweaving through which the authors narrate the meaning of a *very simple* gesture such as receiving a phone call. They attempt to give value to the perspective of human suffering and care that focuses on subjects, not on patients (or therapists); on specific actions of care, not protocols. This is a secure, steady look at a theoretical and human perspective which can be shared in many of its parts.

The human subject to whom care is addressed is described and defined within a real, actual framework that, at the same time, defines and constructs, but also limits, the area of movement.

Although the *depiction* presenting the subject is unique, complex, and unrepeatable, it is also demarcated. We are under the impression that the concept of *welcoming*, which the authors speak of in the psychological consultation, is aimed precisely at the *depiction*, trying to relativize the focus in relation to the *frame*.

It is interesting to regard the perspective that the article proposes with respect to the therapist, who is also placed in a cultural, social and personal framework, and who is taken into serious consideration as the 'subject' of the care proposal and not as the 'background'. This is a role that affects and defines the construction of the care proposal, in its unique and complex subjectivity; it not only reminds us of the therapist's distancing himself from a neutral position (a position which has been rejected in all psychoanalytic conversations, even the most orthodox), but also considers the proposal in the psychotherapist's actions, founded on a perspective that puts the psychotherapist and his own experience at the centre of the meeting, aware that the patient will forever remain unknown and other than himself.

Therefore, within the request for care the position of the psychotherapist and his world (his theoretical thinking, his tools, his culture, his institution, his knowledge, etc.) become of primary importance; a world that emerges and is expressed through what is known as relationality, humanity, or sociality in a broader sense. The therapist's relationality at that precise moment,

Non-commercial use only

interpreted as the synthesis of one personal world meeting another at that given instant.

A perspective that looks at the “meeting system” through these eyes allows the psychotherapist to truly welcome the other on a par with himself, whether he wishes to be seen alone, or in the company of his mother-in-law or pet dog, at a table in a café or hidden in the dark of a video call.

For the authors, the meeting is the real focus of attention, it will always be unique and different, representing a new opportunity in the becoming of the two subjects: therapist and patient. An experience through which the therapist goes back to questioning his own being present and awareness, and in doing so facilitates the possibility that the other subject in the system may do so as well. Thus, there can be no protocol meeting, but a careful planning which allows each moment of the communicative exchange to take place. The first message, the first phone call, the first handshake; but also the subsequent moments of consultation, when it becomes necessary to decide how to meet: in group sessions, with the family, or in individual sessions, etc.

Although Lingiardi’s (2018) definition, “craftsperson’s scientific practice” always strikes a positive chord, we are of the opinion that a perspective which is able to take such complexity into account is profoundly and rigorously scientific, with all the potential to *demonstrate* rather than *explain*, or to *make it work*. Instead, we are not convinced by all those perspectives that go in the direction of constructing manuals, practices, and protocols of technical actions, in which we see the risk of focusing on the frame rather than the painting. This may manifest itself either as discussing the framework of the human subject, or questioning oneself on the issue of diagnosis and how to prepare for a diagnosis; or in dealing with the framework of the meeting and how to smooth out a relationship and make it work.

We might also think that the true essence of *acceptance* lies in the honesty and respect of being able to look at the suffering of that subject(s) starting from the disturbing experience of that meeting; which must be able to be thought of as non-procedurable, because it depends on the uniqueness of that therapist and of that patient, in terms of what they are like, and what coming into contact with the other arouses in them.

Thus, if we follow the direction suggested by the authors, we could say that the therapist is honest if he/she welcomes this new opportunity of experience from the very first contact, being present to him/herself and able to propose a clear and comprehensible care arrangement to those involved. This must be done with respect for the implicit and explicit needs of the person making the request, and sustainability for the whole system of the meeting.

This premise leads us to the crux of Fabio Vanni and Silvia Bertoli’s proposal “Psychological consultation as a transformative first clinical experience”.

Non-commercial use only

To elaborate on this, we quote what they write:

> "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 possible care experience - an "experiential or transformative" objective."

What has been argued so far can be included in the first objective described, concerning the need to accommodate everyone, the requesting system in its complexity and the care system in its complexity, with a view to co-constructing a form of care that is useful and possible for both systems.

Let us now turn to the second objective of the consultation: the 'experiential or transformative' objective.

In order to do this, we shall follow the path taken by the authors, who emphasise the inevitable interconnection between care and subject, considered as two concepts that go hand in hand. We might also add, again quoting the authors and paraphrasing R. Kaës (2007), "neither one without the other, nor without the social and cultural system that contains them".

The idea of the subject in the 21st century brings with it a political dimension and a philosophy of care, as derivatives and concretizations of cultural and social dimensions, with inevitable repercussions also on the ways in which suffering is presented and taken care of.

Although imbued with such dimensions, let us try to examine the idea of the subject that we have in mind and that we propose in our clinical practice.

The authors have clearly described the point of view they start out with, and we are grateful as this helps us to follow and understand their proposal. They speak of a relational subject, who, starting with an 'initial configuration' which, in the course of its existence and in the meeting with the other, defines a 'further configuration' in a continuous becoming between confirmation and disconfirmation, in the tension towards the search for integration and unity.

We should note that this clinical proposal contains and maintains complexity, so much so that the authors underscore the importance of the therapist's posture. This posture is characterized by openness and curiosity towards the world that presents itself through the request for care. It implies an openness to the request and to the implications of having a well-defined scheme, of sticking to the available toolbox, provided by one's training, science and experience: the encounter between the request and the world (system according to the authors) of the request and the world/system of care. These worlds meet and talk in an interactive becoming, leading to an agreed proposal and care.

The focus is not only on the person(s) formulating the request, but also on the person(s) in the care system. This results in an organization, a shared and agreed practice.

Non commercial use only

There has been an interesting follow-up proposal to relativize diagnostics in favour of the presence of the therapist(s) or subject(s) of care. Here, presence involves the possibility of being in continuous dialogue and relationship with the request and the applicant, exploring the various dimensions of the request, the suffering of the subject/s (system including the applicant and his/her vital context of relationship) in the conviction that no one should be excluded. This is a fixed element, to deal with suffering at 360°.

Having acknowledged all the above and more, we shall now ask some questions and propose some nuances.

First and foremost, the idea of a unitary and relational subject, the cornerstone of the thinking and proposal, is backed up by the specification of an initial configuration that evolves through its relationships, maintaining the need to be unitary, which finds continuous confirmation and disconfirmation in the encounter with the world. Hence the evolution from the initial configuration to the subsequent one. From this theoretical premise derives a clinical practice with the presence of the human subject; in this Comment, the patient who has turned to the service and the therapist(s) who received him/her.

We think it is useful to explain in what way it is considered possible to accompany the suffering subject towards a presence to oneself. Towards a consistency and quality of life and its unfolding.

As mentioned by the authors, each person becomes in relation to his or her history and relationships. In that becoming, the relationship with the other takes on nuances and modalities functional to each one.

However, remaining on a level with connection and disconnection, between the confirming and the disconfirming, seems to us to remain on a level with the functionality of relationships. So what does it mean to take suffering into one's care? We certainly agree with the authors who propose a posture of listening and welcoming the other(s); hence, a posture of interest and listening to the other's world, to the exertion in taking on the commitments of one's own life. Respectful listening and curiosity lead the way to paying attention to the different nuances and subjectivities in the field.

It is the respectful listening to their world, to their solutions and their exertions that encourages them to be there, supporting them whilst dealing with them.

However, we find it difficult, but perhaps it is just a matter of language, to think that suffering lies in the disconfirmation of one's identity, produced by events or relationships. Indeed, although disconfirmation brings with it fatigue, we could place suffering in the position of passivity and impotence that the subject perceives when faced with that particular situation. Thus, we would not place the emphasis on the relationship, but on the readiness of the individual subject to accept and face what life proposes to him.

And here it would be useful to introduce a further concept in the theo-

Non-commercial use only

retical references proposed by the authors: there is certainly a configuration, and certainly the unfolding of life is in the relationship, but suffering lies in the difficulty in making the effort, pursuing the possibility and opportunity that "the consciousness of consciousness" can offer us (Minolli, 2015).[1]

This perhaps accompanies us in presence and quality of substance in our becoming.

Thus, any discourse can only start with the idea of the subject that we have in mind. As far as we are concerned, we define it, as Minolli suggested, an I-subject. It is not a quirk, but I-subject defines an idea of the world, of the living and the human being.

The meta-theory of the I-subject leads to the view that each living being is unique, belonging to its own mode, self-organized and in continuous search for functional solutions for self-realization. Therefore, each subjective posture, one's own way of being in the relationship, has its own functionality, which on the one hand produces functional 'relational configurations' for the individual subject, and on the other informs us about the individual subject, their way of being, the solutions found and the exertion of proceeding in one's own existence.

What does this way of understanding the world entail? Firstly, that the solutions found by the living, and thus by the I-subject, are always functional, provided one places oneself in the point of view of the individual I-subject.

This means that the outside, the other, cannot define the solution found by the I-subject. It is not possible to define that solution as functional or dysfunctional. If a solution exists, it means that, from that subject's point of view, it has its own functionality in relation to its way of being, to feeling alive and maintaining a coherence of self.

We believe this is where we should start! So, how does suffering come into the picture?

Does it make sense to talk about dysfunctional solutions (thoughts, actions, relationships, etc.)? Does it still make sense to talk about psychopathology?

Does suffering have to do with psychopathology or with the subject's life process?

If the psychoanalytic clinic does not have anything to do with psychopathology, then it is necessary to define criteria and modalities to accompany young colleagues approaching the world of psychotherapeutic training.

Non-commercial use only

[1] Through the long, slow process of 'consciousness of consciousness' it is possible to acknowledge one's own configuration to oneself. Life in its continuous unfolding can make us relativize the sensations of 'consciousness' .... This processual acknowledgement to oneself that one is configured that way... leads to the presence to oneself through the qualitative work of the 'consciousness of consciousness'. (Minolli 2015, p. 233)

This is necessary because the order of discourse is subverted.

The approach to the clinical practice has had a directionality that starts with suffering as a derivative of psychopathology, and the dysfunctionality of certain behaviours, thoughts, relationships, in search of the underlying factors, and the indication of possible solutions for a return to a situation of well-being. We do not believe that this is the authors' vision and proposal; however, we believe that if we consider the relationship as the transformative tool in the therapeutic meeting, in particular in the specifics of the consultation, this could lead to a relational exasperation to which one could attribute a power more capable than what the single experience of presence is capable of assuming, thereby saturating one's own experience.

It is something else to deal with the individual subject and his suffering, inherent in his life process, not something 'other', salvific, healing.

Dealing with the process of the individual subject means leaving behind the asymmetrical position and standing side by side with the suffering patient. A relationship on an equal footing, in which one shares the issues of life, and in which one is accompanied, each one of us in the position we find ourselves in, to a knowledge and acceptance of one's own existence.

We can call this modality the "Clinical practice of Presence", where the subjective process of the therapist meets that of the patient and, in the encounter, there is an accompanying self-knowledge.

From these premises a revolution arises in the conception of the clinical practice, no longer aimed at overcoming a problem, but at welcoming it as an element in one's own life process. It follows that taking charge cannot be standardized, but must be personalized; in relation to that unique patient and that unique therapist. In this point, too, we are broadly in agreement with Vanni and Berboli.

It is customizing in relation to the process of the patient and the therapist, where the intake is unique and follows the process of becoming of the two interacting subjects.

For us, too, the devices are relativized in their scope and proposals, and used as a function of accompanying the subjective process which is underway. This means having the propensity to be in a relationship with oneself and with the other. To be in the suffering, in the tortuous paths that subjects take when taking their lives in their own hands, as well as the tasks that life proposes as it unfolds.

Learning the techniques and tools, paying attention to the definition of the setting, knowledge of definitions and diagnostics and testing formulations, do not have the same meaning as they have in the psychopathology-based clinical practice. But this does not mean they should be neglected. Their possible use should be defined, made explicit and agreed upon in the relationship between therapist and patient.

Therefore, sustaining the presence becomes the foundation of training.

In line with F. Vanni and S. Bertoli's proposal, this does not concern the acquisition of skills regarding the use of items such as the individual, the couple, the family, etc., but rather a training or, rather, training in 'posture' or, to be in line with our language, 'Presence'.

In conclusion, we feel we can share with the authors the spirit of research and an ethical posture of listening to the uniqueness of the subject, whether sufferer or professional, to the complexity of the question and the uncertainty of outcomes.

However, we have some reservations about considering the consultation a foretaste of a possible transformative clinical practice, for two reasons: on the one hand, because we think that the aim is not to transform, but to embrace what one has and what one is; on the other hand, we fear that one might run the risk of pointing out the direction of a solution for the crisis and the suffering.

For this reason, we think it is useful to accept the request for care, leaving open the possibility of meeting the requesting subject, or extending the proposal to meeting other subjects with whom the applicant has significant affective relationships. This openness, similar to F. Vanni's and S. Bertoli's proposal, lies in the conviction that significant relationships organize functional 'relational configurations' for each individual subject. In this way, the request for care can only represent the tip of the iceberg of a personal crisis that also finds a correspondence in others.

Accommodating the individual or several subjects responds to the logic and theoretical conviction that it is neither the device nor the 'relational configurations' that are the focus of our interest; rather, both are considered as elements to support the life process of each subject with whom we enter into a relationship. Consultation is this possibility that subjects are giving themselves, and we may perhaps support them in this opportunity.

There are other issues and reflections that could be developed, the text is so well organized and clear in its exposition that it stimulates thinking and dialogue.

However, as we believe this dialogue is only a moment in the process, we have chosen to stop here.

Non-commercial use only

REFERENCES

Abbruzzese, M., Vincenti, E. (2024). Prendersi cura della sofferenza all'interno di una famiglia. Ricerca Psicoanalitica Anno XXXV, n. 2, 2024.
Alfieri, L., Vincenti, E. (2022). Quale setting per quale sofferenza. Educazione sentimentale. FrancoAngeli, n. 37.

Non-commercial use only

Conflict of interests: the authors declare no potential conflict of interests.

Ethics approval and consent to participate: not required.

Received: 7 December 2023.
Accepted: 16 October 2024.

Editor's note: all claims expressed in this article are solely those of the authors and do not necessarily represent those of their affiliated organizations, or those of the publisher, editors and reviewers, or any third party mentioned. Any materials (and their original source) used to support the authors' opinions are not guaranteed or endorsed by the publisher.

©Copyright: the Author(s), 2024
Licensee PAGEPress, Italy
Ricerca Psicoanalitica 2024; XXXV:955
doi:10.4081/rp.2024.955

This article is distributed under the terms of the Creative Commons Attribution-NonCommercial International License (CC BY-NC 4.0) which permits any noncommercial use, distribution, and reproduction in any medium, provided the original author(s) and source are credited.