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Review Article

Psychological Consultation: A Meeting of Subjects that Takes Place in a Social Context

Fabio Vanni[1]* and Silvia Bertoli[2]

[1]Psychologist Psychotherapist, Former SSN Manager, President Sum ETS Project and ETS Social Psychotherapy Network. UNIPR tenure lecturer, Italy
[2]Head Psychologist Psychotherapist c/o NPIA ASL in Parma, Expert in Childhood, Adolescence and Developmental Psychodiagnostics, Italy

Corresponding author: Fabio Vanni, Psychologist Psychotherapist, Former SSN Manager, President Sum ETS Project and ETS Social Psychotherapy Network. UNIPR Tenure Lecturer, Italy

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Abstract

We propose here a conceptualisation of the first step in each patient's clinical journey. To do this, it is necessary 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. This paper wishes to deal with consultation as a clinical process having a general scope: 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.

Keywords: *Psychological consultation, Psychotherapy, Psychodiagnosis, Subject, Relationship, Child, Adolescent, Family, Network*

Setting Up the Meeting

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 [1,2] that takes place in a social context [3]. 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' [4], 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. 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. 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. 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. 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. 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.

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. 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 therapeutic indications. The clinician does not know the patient 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. 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 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' [5,6]. 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. 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?

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 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, sufficiently 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.

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 are 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.

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