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About diagnosis

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The present work aims to show how important it is to maintain the problem concerning diagnosis unsolved, in spite of the fact that the diagnosis is, within the theory of personal constructs (PCT), a transitive and temporary construction. Considering diagnosis as an interpretative process that recursively orients us towards an understanding implies that we stay within a movement that directs but does not determine, that opens possibilities but does not reach definitive conclusions. Through the clients' stories we show how our wondering about diagnosis enters in our relationship with the client and how it can expand our choices in a process of knowledge which can be followed but not acquired.

Keywords: *transitive diagnosis, therapeutic relationship, responsibility, ethics, hermeneutic constructivism*

Considering that, according to the Personal Construct Psychotherapy (PCP) proposed by George A. Kelly (1955/1991) and its further development within the perspective of hermeneutic constructivism (Chiari, 2016; Chiari & Nuzzo, 2010), the sense of a "diagnosis" is to open up new possibilities, avoiding as much as we can to explain everything, to "objectify" what we affirm, and to reach conclusive affirmations, we are aware that it demands us to pay constant attention to the risk of inadvertently slipping away from it.

Each time we formulate a diagnosis, we should be increasingly able not to identify ourselves in what we say and in what we presume to know, with the idea of trying to work with a wider awareness of what we do. We therefore attempt to look at the matter concerning diagnosis keeping the attention high on how it is difficult even for us, as therapists, to abandon the presumption of truth.

Assumptions

Moving from this idea, we highlight the theoretical, epistemological and ethical assumptions within which we move, as constructivist hermeneutical psychotherapists, considering them as practical and active ways that orient us in our knowledge.

1. Knowledge is a relational phenomenon.

2. To know means to set "sign relations".
3. Each "practice" specifies the world in a peculiar way.
4. Language has a "generally objectifying power".
5. Knowledge is constructed on the basis of a method.

Showing them one by one, we will refer to the *theory of autopoiesis* by Humberto Maturana (1987; Maturana & Varela, 1987) for its original and precise invitation to place the observer in the very centre of the process and phenomenon of "knowledge", and to the thought of practices by Carlo Sini, for its wide and rigorous philosophical investigation on the question of the sign within the reflection on the foundations and origins of our knowledge related to "truth".

Within the constructivist hermeneutic epistemology and as long as the reflection on diagnosis here presented is concerned, the *thought of practices* by Sini (2009) is a precious contribution. It offers on the one hand a point of view that reaffirms the constructive/interpretative character of experience, and on the other hand the possibility of approaching the problem of knowledge moving from the analysis of the relationship between sign, signification. and interpretant.

Knowledge is a relational phenomenon

Assuming, as Maturana (1987) does, that "existence is specified by an operation of distinction" (p. 370), means looking at knowledge as a process that implies on one hand an attempt to get close to an assumed and unknown object, and, on the other, a way of gathering it from a certain distance. The occurring process of construction that takes shape specifies at the same time the object and the observer who, as a construing person, participates in it. According to the perspective of hermeneutic constructivism, knowledge is always an enactment: we cannot know something which is "out there", as if it were independent from us, since subject and object are immersed in the same world (Armezzani & Chiari, 2014). As Sini (2012) underlines, knowledge is by nature perspective and therefore relative; it emerges by standing at a distance and, in its happening, each time in its determined ways, it is relational, it constitutes itself in a system of relations from which it is not divisible. In these terms, "nothing pre-exists its distinction" (Maturana, 1987, p. 370) and, once it is distinguished, an entity has no continuity beyond the constitutive domain which specifies it and beyond the relation of being something for someone.

Implications for the therapist: it is important to consider that no interpretation can be a more faithful construction of the thing itself, including the diagnostic hypothesis that we are about to formulate, since "the thing itself" is impossible to approach and reach.

To know means to set "sign relations"

We start again from the consideration that, even though nothing can exist in a "substratum independent of the observer" (Maturana, 1987, p. 371), expecting that substratum is an "epistemological necessity" (Maturana, 1987, p. 371). The moment we operate a distinction, we are dealing with a question which searches for the object of our distinction and assumes its existence as previous to the operation of distinction. In this perspective, knowing takes shape by signifying something by something else. As Sini (1999, 2004) affirms, the object appears as it gives a sign of itself, "something therefore assumes the value of a sign, it carries out the function of a sign, exclusively as it transmits, embodies, 'conveys' a meaning (that is to say it signifies something else)" (Sini, 1999, p. 6, translation by the authors). This is the modality of knowing. The relation sign/signification is part of a signifying relationship, whose outline is triadic (interpretant-sign-object, or signification), that is, "the relationship" between sign and signification is determined by an "interpretant" (Sini, 1999, 2004).

Implications for the therapist: the interpretant is not someone who pre-exists, who connects sign and object from the outside, who ascertains that a sign corresponds to a certain meaning. Therefore, we as therapists must keep in mind that we are immersed in an experience, in a circumstance, that determines the meaning of our actions, so that the event has for us that particular meaning because we are part of it.

Each "practice" specifies the world in a peculiar way

When making experience we are constantly immersed in worlds, in universes of meaning which constitute us as observers, or, as Sini defines, "practices to which we are subjects" (Sini, 2009, p. 145). Each knowledge is therefore "a practice, a [form of] 'wisdom' sui generis" (Sini, 2009, p. 104), it has an active and executive character, it moves us and inspires us towards an answer. We participate to a meaning in which we are preliminarily immersed, and it is in its accomplishment that significant and object coincide, that we can experience a world, things, and ourselves. Within such concept about knowledge, "a cognitive affirmation is an invitation to participate to a certain domain of experiential coherence" (Maturana, 1997, p. 17, translation by the authors). As Maturana points out, this means that "the different worlds that we live as human beings do the different kinds of things that we do" (Maturana, 2006, p. 97). Besides, each practice assumes and transforms elements from other practices, giving them a new meaning (Sini, 2009).

Implications for the therapist: psychotherapy, as any other practice, is connected to other practices and it is a variable interlacement, an indefinite and nuanced set of many practices, and it cannot be isolated in itself (Sini, 2009).

Language has a generally objectifying power

We are constantly immersed in "manners of languaging that take place as if objects existed outside of language" (Maturana, 1987, p. 363). Language "employs its generally objectifying practice by establishing and conveying 'objective' meanings, that is public and intersubjective, common to everyone" (Sini, 1999, p. 13, translation by the authors). Therefore, the practice of language is "the general place where all the other practices are translated" (Sini, 1999, p. 13, translation by the authors), from which it assumes objects and inadvertently converts them into meanings which persist beyond the concrete operations that have specified them.

We continuously talk, write, read, and deal with words as they reflected a corresponding and supposed reality itself. Words on the contrary are the sign of an object that is the linguistic meaning; they acquire and maintain their meaning only within the practice of language. The practice of reproducing words is intertwined with an endless number of other practices and it is modelled differently each time, in the shape of distinguished and peculiar languages. Thus, when we name "objects", we use at the same time our specific language and the practice of language as common to us all (Sini, 2004).

Implications for the therapist: the "generally objectifying power" of language is not something that one can avoid. We must understand its action, see its limits and possibilities in order to use it in a useful and conscious manner.

Knowledge is constructed by following a method

Any observation implies a perspective which takes shape from theoretical concepts, both explicit and implicit, which determine it. The perspective determines what can be observed or not, and whether that can be validated, explained or not (Maturana & Varela, 1980). Each method, as Sini (2013) underlines, "embodies a standpoint, a defined option. So, each method contains, aware or not, an option of knowledge […]. Each method is therefore a vicious circle: it must already know something to reach the knowledge it is searching for" (p. 15). The atten-

tion must therefore be always pointed towards that 'knowing something', which remains a groundless, unfounded and even incapable of being founded knowledge, but it is the basis without which the inquiry could not even start. The method is a tool that implies an attitude to action, an act which specifies the world it distinguishes. When knowing, when having experiences, there is always something already decided and known; it is not possible to put everything in brackets, because each exercise always uses a set of premises and constructions.

Implications for the therapist: the presumption of eliminating every premise is impossible, we must have already interpreted in order to interpret, but maybe we could think that the premises do not harm knowledge, and that having a perspective is the only way to have a vision (Sini, 2013).

Shifting to ethics

Since the presumption of understanding "the object in itself" disappears, the opening of meaning and the object of our knowledge do not correspond anymore, they are on two different levels. To operate this shift shows the duplicity of each specific knowledge, of each "practice": on one hand its peculiar opening of meaning, which takes shape in a particular perspective; on the other hand, the specified elements, coordinated and organized according to the opening of that peculiar meaning (Sini, 2009). Being aware of moving within a knowledge which specifies objects and orients our choices, we must give visibility to the process through which the objects emerge and the relationships from which they cannot be separated. Therefore, it is not about questioning whether what is affirmed is "true", nor recurring to a knowledge which can validate and explain it, but it is about getting referred to an ethics which allows us to evaluate the meaning by putting attention to the "practice" that we are subjected to (Sini, 2009).

Thus, the ethical awareness is a peculiar disposition that implies a specific assumption of responsibility regarding the manners of our asserting and acting. As Keeney (1983) underlines "the method by which 'data' are 'captured' (diagnosis) is one of the ways in which the therapeutic context is constructed and maintained. In other words, the therapist's questions and hypotheses help create the 'reality' of the problem being treated" (p. 21). The perspective of a self-referring and participating epistemology is a paradigmatic change in which as Howe and Von Foester (1975, cited by Keeney, 1983) affirm, the concern with objectivity is replaced by the one of responsibility.

Maintaining the interest towards what moves us each time permits us to evaluate from that perspective the meaning of the knowledge we embody. Meanings can only arise within the horizon we are in. That can happen according to perspectives and ways that are defined and delimited by practice and that, for psychotherapy, regard "the psychological reconstruction of life" (Kelly, 1955/1991a, p. 23), and they are focused on the personal change. As Maturana (1987) states, we must evaluate the adequacy of our own actions with the operative coherences of the domain to which we belong, so that we can guarantee a criterion of validity. We must move and orient ourselves in our professional acts considering that "we are dealing with constructions which can result more or less coherent, sustainable, and viable" (Von Glasersfeld, 1999, translation by the authors). Thus, shifting to ethics means being in an exercise of self-awareness which can never be concluded, it is a way of standing at a distance which allows a self-reflection and which has to be continuously repeated. Knowledge can be travelled but not acquired.

According to PCP, it is only when we face a choice seen as more "elaborative" (Kelly, 1955/1991a, b), that we can abandon the old habits, therefore only when facing a rich and useful possibility we will not need to fix the truth in the meanings that we will construe each time.

This choice, which we consider as the “transitive diagnosis”, does not need to be true, or even objective-subjective, but a “valid”, “accurate”, “fertile” (Kelly, 1955/1991a, p. 456), and “modifiable” (Kelly, 1955/1991a, p. 30) base from which treatment hypotheses, viable and verifiable, can arise. If we remain aware of the practice to which we are subject, the acts of not fixing and not getting to definitive conclusions are not considered anymore as actions expressed by “not”. Within the practice of psychotherapy, the meanings are intensely and concretely gathered precisely in their being part of a relationship with the client. It is not a deficiency, if we do not lock ourselves into an answer, in a character that embodies the “objective truth”.

Transitive diagnosis

On that suggestion, we shall develop the topic about diagnosis, highlighting the ways with which it supports and orients us in the process of knowledge.

We could start considering the diagnosis as a door, an access -from the Greek ‘dia’, through-, thast allows to enter, to give shape to a process of knowledge (‘gnosis’, to know). What kind of knowledge are we considering?

The “transitive diagnosis” concerns the transitions, in the life of a person, the “bridges” between his/her present and future, and it is the planning phase of a possible reconstructing and reinterpreting process.

It is designated to understand the experience of a person in order to bring out the possible paths along which the client and the psychotherapist can proceed towards a solution of the client's problem. On understanding, there are three important elements:

- To understand the experience of the other means to deal with the personal construction that the other has about him/herself and the world. Therefore, the object that our knowledge presumes is the person, but not in absolute terms. To understand the “knowledge of the self” of the person.

- Understanding is always an active interpretation put into “practice” -which derives from a long chain of practices of thinking and conversational experiences- that is for us a profession of “health and psychological reconstruction” (Kelly, 1955/1991a, p. 19). An understanding aimed at taking care in order to reconstruct.

- Understanding is an interpretation, a construction that does not remain unperceived and unmotivated but it is interpreted and construed by those who understand. This understanding is always peculiar and it has sense exclusively within its own practice. Understanding therefore takes shape from and within the peculiar language of its knowledge.

Chiari (2009, October) maintains that “understanding, differently from description and explanation, requires the clinician to accept the person of the client, to assume responsibility, and it allows to make hypotheses about the client's disorder” (slide 17th). It is not just impossible to “crawl into another person's skin and peer out at the world through his/her eyes” (Kelly, 1991a, p. 42) but this way of coinciding would not be a knowledge anymore and would not allow any kind of understanding. The interpretation implies a distance: “the construct is an interpretation of a situation and is not itself the situation which it interprets” (Kelly, 1955/1991a, pp.109-110).

The PCP language has been formulated with the idea of making explicit and perceived the constructive nature of understanding. Thus, the setting “at a distance” of our understanding is not considered anymore as a lack, but it takes shape through the professional constructs. Kelly underlines that understanding the experience of the other, for us therapists, is always a construction process which can be carried on with accuracy as long as we are aware of that, we

act within clear differences allowed by the dichotomic nature of the constructs, and we make explicit the constructions that orient us in this specific process.

Among the professional constructs there are the diagnostic constructs, on which the transitive diagnosis is formulated and which do not have the function to allow the therapist to distinguish a client from other people, but instead they assume the most important ways in which the client can change. The formulation of hypotheses by the therapist is the result of continuous choices (Kelly, 1955/1991a, p. 25) which require the disposition and the instruments to examine what has been professionally acted, according to what happens in the therapeutic relationship. The transitive diagnosis is also a temporary one: it is never conclusive but subject to evolution and revision. The therapist always returns to the initial questions and take into account if their strategically oriented perturbations allowed to facilitate and activate the expected and professionally anticipated change, within the constructive process of the client.

Let's get into the stories: Francesco

Let us try now to approach the topic of the diagnosis following the standpoint we have outlined so far, through the brief story of a therapeutic treatment.

A few years ago, I was contacted by a man around forty, Francesco. During our first session, he told me that one day, some months before, while walking, he saw a syringe on the street, and from that moment on, "all of a sudden", he started to fear to be infected by HIV. He reported that "he could not live anymore due to a permanent anxiety of being infected": he could not think about anything else and he had constantly to be sure not to walk on any syringes. He said he felt "trapped, blocked, with no way out", and that therefore by then he used to move as little as possible.

I remember the sensation I felt with him during our first session: I felt trapped, just like Francesco, unable to move in any other way except the one of the symptom, something happened all of a sudden, a recurrent and pervasive fear, a thought impossible to get rid of. During the following sessions, having encouraged the willingness of Francesco to broaden the conversation topic beyond the reported problem, I got to know that he was "happily married" and father of a four-year-old son to whom he was very attached. Francesco and his wife work full-time, so they "rely too much upon" their parents to look after their son, and that makes him feel uneasy. Francesco explained that he was "used to solve his own problems alone", and so it hadn't been easy to decide to go to a psychotherapist. He felt he was not helping his wife much: he would have liked to support her a lot more, by playing an active role in the management of the household. Also with his son Francesco felt that he was "defective" and that he had less and less patience with him (he often shouted him), and he also regretted that he had never imagined that being a father would have implied so many responsibilities. Francesco anticipated that a psychotherapy would have "set him free" from the recurrent thought tormenting him, in order to return to be who he had been "before".

Let's show you an initial potential comprehension of the case.

Francesco is having a repetitive, and lacking of perspective, experience, what highlights an arrest in the constructive process. He is a person, with a constructs system which appears simple and poorly articulated, with few role constructs. Some constructions have become very permeable, so that he reads everything in terms of "infection". Each explanation seems to rely on the same meanings without embracing new elements and forming new constructs. Some constructions are very preemptive, thus easy to invalidate: "good father", "good husband", "good son".

I hypothesize that Francesco faced a transition of guilt related to the role of someone who "helps the others", "solves the problems by himself", takes his own "responsibilities". His anticipation about the possibility to play this role faced invalidations repeatedly, since he had, on the contrary, to "lean on" his parents and he felt that he "couldn't manage to help" his wife enough. His sensation of threat is constant, and Francesco is facing it with constriction about different aspects of his life.

Questions which place and orient ourselves

The professional hypothesis described above, even if it is plausible and coherent with the premises and the assumptions of the PCP, appears as being formulated "by default". Describing a core role "in a few lines", as if the recurrent ways of moving in the relationships with the others could be briefly summarized, helps us construing the experience of the client, but on the other hand it exposes us to the risk of considering the role as something "which exists in itself". We bump into the implicit limits of the use of language as if the words indicated something "real", static, conclusive, "something that explains everything".

Which alternative do we have in order to take into account the "objectifying power" of language and at the same time to perceive something else? What are we doing when we define a core role or a professional hypothesis? How can we enter them within the experience of a therapeutic role with the client?

Here are some questions that we are going to consider according to what has been said so far.

Facing the complexity and the relevance of the implications about ~~the~~ diagnosis, we often find ourselves underlining that within the PCP we do not operate a distinction between diagnostic and therapeutic phases. We do this with the intention of keeping in mind the meaning of our actions and we are aware that moving in a therapeutic orientated way is the background that we cannot ignore. Having the same aim, the diagnostic and the therapeutic phases emerge in their difference exclusively within the construction that the therapist has about the therapeutic process. The diagnosis is not formulated on other assumptions or goals and then adapted to "reconstruct the life of the client", but it takes shape on the meanings which emerge and exist as much as they allow an elaboration and a solution of the client's problem. Therapist and client join a common venture, as they try to take care, to understand the discomfort, and to search for a change in the client's experience. Only then, in the experience of the therapeutic meeting, in a reflective way, each one construes the meanings, professional on one side and personal on the other. Within this framework it becomes even more important to consider that the common experience cannot and must not be taken for granted, it is doing something together, which is continuous and cooperative, on which the therapist must have a professional construction. Through the dialogue one can co-construe a shared background, the "circumstance" in which experiences can meet, a relationship in which the possibility to play a role with the other is created. In a way, the diagnostic constructs realise their meaning in their being played within the relationship, they are therefore a dynamic and concrete support which places and orients ourselves in our experience with the client.

The transitive diagnosis becomes an elaborative choice: our specific language, the professional and diagnostic constructs enable us to make clear the pre-constructions from which we start, the direction towards which we are moving, the hypotheses that are orienting us. We continuously face choices and interpretations which turn into actions, we experience according to questions which determine what happens inside that relationship, in a specific moment and perspective. Any "intervention", any choice we operate within the relationship with our client implies an hypothesis, an anticipation, a way to look at the other and at their experience; it is starting from this pre-understanding that we can construe an understanding, and that we can

play a role with them within the relationship. We must have already interpreted in order to interpret. Knowledge is therefore an experience that is never completed, that takes shape as a possible part of what it tries to know and that is always a new way of recognising. The everyday experience with the clients teaches us that even if we have chosen this perspective, we tend to distance ourselves, sometimes inadvertently, from what we are doing and we are captured within the practice of language and its generally objectifying power. As Chiari and Nuzzo affirm (2010), we, as therapists, can find ourselves thinking that "the clients are 'too loose' in their construction of themselves, 'too impermeable' or show 'little aggressiveness'" (p. 171), as if these were "traits", existing in themselves, with a reality of their own. The professional hypothesis, treated as real, remains separated from the practice from which it arises, from the experience we are having with the client, as well as from their personal experience.

Moving on to Francesco, neither "the obsession" nor the hypothesis made by the therapist exist "in itself"; the "diagnosis" has inevitably to deal with what the therapist and Francesco construe, act, experience within the therapeutic relationship.

Considering again the exercise, we can now try to look at the professional construction, observing its execution, the cooperative and creative aspects, and thinking that it is never "over"; with this awareness, we can move in a responsible manner within our knowledge and with our clients.

Let's get back to Francesco

Every attempt to expand the possible meanings, that is my initial therapeutic choice, fails: Francesco seems to see a meaning in talking exclusively, in a repetitive and persistent way, about his fear of being infected by HIV, about the necessity to check where he puts his feet and about the absurdity of all this. He asks me for explanations, but I feel he is not willing to listen to what I might tell him. In this phase the hypotheses I follow, the questions which move me, the way I look at Francesco and at the experience he is having, is in a way separated from what he lives with me and in his life. It is as if each of us stayed where we are with no chance to meet. My hypothesis is in some ways "made by default", as if I looked at Francesco and his disorder in a way which is separated from what I live with him in the therapy room.

For a moment, I am tempted to "contrast" those obsessive thoughts, just like Francesco does with himself when he considers them as "absurd" and "irrational". That is a lost battle. He sees needles, needles are "contact", contact is "infection". Stop. We are both stuck.

Francesco does not get to me with a diagnostic label, nor I use it, but the experience I live with him is similar to the one I could have if I construed Francesco as a person suffering from an "obsessive disorder". The symptom, as an "object", seen as if it existed in itself, outside our personal experience, snags me in a net poor of meanings, construed in a preemptive way, from which I am unable to figure out alternatives. We cannot escape from a way of telling about ourselves which is distressing, overloaded, like a bottleneck.

Perhaps this experience, leaving me impotent and irritated, allows me to stop and ask myself in which way what I am living could be given back to Francesco, and how this could let us shift the level of our experience. Francesco considered many things as "obvious", taken without elaborating their meaning. I tried to go beyond what even to me, seemed obvious: is it obvious that it is an "absurd thought"? Is it obvious to think that anyone who is HIV positive must fear death and suffering? Is it obvious that Francesco does not know why he is experiencing all this? Is it obvious that one has to search for a meaning hidden "behind" a symptom and that Francesco does not know?

From all these questions, a different therapeutic choice arises, which leaves the level of explanation and of the block with no way out, in order to access the level in which we can ask questions together, expanding the space of understanding and experience and opening to possi-

bilities never explored so far. I ask myself and him how he feels in relation to what he thinks he will face, to what he is experiencing within his important relationships, and to what cannot be carried on anymore.

The questions, emerging from diagnostic hypotheses, orient me in the relationship with my client and they continuously renew themselves. Questions generate new questions in both of us, opening further possibilities. The experience lived together is a form of movement, it changes as we are living it, as we are talking about it, as something between us happens. We leave the level of explanation, of the obsessive thought as something which exists by itself and which we want to get rid of. I shift from the level of a "construction made by default", to the one of understanding, of the cooperative exercise, of the shared construction of meanings. The "diagnosis" prepares me for the action, allowing me to move in the relationship with Francesco and to construe new meanings with him. We manage to get out of the impasse. In order to show how this change of perspective occurred and to go beyond what can appear "obvious", a passage of our therapeutic conversation is reported:

T.: "Thinking about the chance of being infected by HIV, what do you reckon it could happen?"
F.: "I am afraid of getting ill."
T.: "And in that case, what do you fear more?"
F.: "The others…"
T.: "The others?"
F.: "Yes, the fear of infecting someone else."
T.: "Mmh…"
F.: "I've even considered sometimes the chance of leaving home…"
T.: "Not to infect the others?"
F.: "Yes"
T.: "In other words Francesco you are saying that if you got infected your main concern would be that of infecting your wife and son?"
F.: "Yes…. (he is moved)"

During the following sessions, it took shape the attempt to play a role together, which allowed to question the acted constructions, still carried on despite their repeated invalidations. As reported in the passage above, we realized that in case of being infected by HIV, the anticipation is not much about suffering or dying, or not being able to help someone, but it is about infecting the ones he loves. "To harm the others" is what he fears the most. We can now access more easily to the relationships level and Francesco tries to tell how it is difficult for him, in everyday life, not to feel being "helpful" but on the contrary "useless" or even "harmful" for the others. The attempt to maintain the role of a "responsible" person (vs person who can be of harm for the others) that Francesco tries to make with such effort, avoiding the infection for himself and the others, acquires new meanings.

F.: "Sometimes I think about leaving"
T.: "How would you feel if you did it?"
F.: "I would feel that I wouldn't give problems to anyone anymore"
(silence)
T.: "Besides the possibility of being infected by HIV, is there anything else which makes you feel like that?"
F.: "A burden?"
T.: "mmhh…"

F.: "Yes, maybe… I can't help my wife with our child… Everything is on her shoulders… In that sense, I feel I am a burden."

At this point Francesco tells me how sad and sorry he feels, for not being able to be the person he has always felt to be for his dear ones. He tells me how he feels like a burden to his wife -he would like to be a different kind of husband for her- like a weight for his parents, and even towards his son, with whom he feels he is not able to be the kind of father he wished and expected to be.

The conversation is shifting, I start breathing again and so does Francesco, I believe.

Conclusions

We are psychotherapists and we must never forget that we are subject to a long chain of cognitive and conversational practices in the light of which (the) experience, through the words, becomes for us "psychological". We must not and we cannot, starting from this consideration, confuse the chain of interpretative events with the "object", in our case "psychological", which does not exist in general, but it is present within the circumstances of the practice from which it emerges. What we observe is not the "psychological experience" (that) the person has but instead the fact that something assumes for us the meaning of psychological experience that describes and explains the client's experience.

The "diagnosis", even though transitive, and the "disorder", are inside our practice. Through our meanings we give shape to an analysis, a translation of something which can never be fully told, and of which our way of construing offers a possible form.

If we accept to consider that to know is "to be at distance", the diagnosis acquires its own value, since as a material support, it allows us to position ourselves in a dual manner within knowledge: on one side it allows us every time to bond the meanings to the questions, to the assumptions we are starting from and to the practice we are subject to; on the other side it allows us not to renounce to the attempt, always partial and always renewed, to catch the object, and to identify it into the meaning. It is the continuous shift between these two aspects that lets us use our specific knowledge as an exercise which is concretely accomplished through a second reading, allowed by the diagnosis itself.

As Sini (2009) underlines, we can renounce to the demand of having a truth that can exist outside our practice only if we can recognize in the exercise of the hermeneutic circle a possibility of knowledge so usable, rich and profound that we will choose it fully, with coherence and courage. It might sound strange, but it is the attempt to understand and not understanding, the ground of knowledge and it is what puts us in the conditions to operate a reasonable and fruitful action, careful about the process and respectful to the lives of people.

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