The report and the diagnosis

by Renzo Carli*

Introduction

In a previous work (Carli, 2007)[1] I proposed a definition of the report and some methodological suggestions for its use in clinical psychology.
The report acquires meaning and usefulness only in a specific conception of clinical psychology, where the *relationship* is considered the means and the object of the intervention.
Focusing the relationship means the development of a theory of the technique that is to be used in intervening in the relationship, in a way that is consistent with the individual-context paradigm.
This approach is in contrast with other different visions of clinical psychology, which identify it with the study and treatment of psychopathological phenomena. When clinical psychology is likened to the diagnosis and treatment of psychopathological disorders, since psychopathology characterizes the individual, one implicitly accepts an individualistic vision of "psychological" problems. Psychopathology, in other words, conceptually and pragmatically limits its interest to the individual and to the deficit presented by the individual, as a deviation from normality.
I will briefly consider two of these *visions* of clinical psychology, both trying to confirm the identification of clinical psychology with the diagnosis[2] and treatment of specific forms of psychopathology. One of these schools of thought is linked to the "verification of psychotherapy"; the other to "health psychology". The first, as we shall see, *must* liken clinical psychology to psychopathology, to be able to anchor the verification to a modification of the conditions diagnosed *before* the application of psychotherapy; but also to understand the psychotherapy process in psychopathological terms. The second *must* relegate clinical psychology to the domain of diagnosis and treatment of the psychopathology, in order to occupy the theoretical and pragmatic space that clinical psychology is thus forced to "vacate". The reasons are different, as can be seen, but both aim to restrict the theoretical and pragmatic domain of clinical psychology.
Before making some comments on the report, I intend to present some brief critical comments on the two models that reduce clinical psychology to psychopathology which, as I have just said, can be called "verification of psychotherapy" on the one hand, and "health psychology" on the other.

Health psychology in Italy

A recent vision of psychology is often anchored to the terms health and well-being. It is important to notice that these two terms, clearly deriving from medicine, are strongly and inseparably tied to the individual. Metaphorically it can be said that a firm enjoys good or bad "health"; it can also be said, still in a metaphorical key, that a couple's relationship is not very healthy. But health and well-being are aspects that usually refer to the single individual. It is usually said that health psychology entails a new vision in the field of psychology and of psychological practice: it does not deal with

* Full professor of clinical psychology in the Faculty of Psychology 1 at the University "Sapienza" of Rome, ordinary member of the Italian Psychoanalytical Society and of the International Psychoanalytical Association.
[1] Carli R. (2007), Notes on the report, *Rivista di Psicologia Clinica. Teoria e metodi dell'intervento*, 2, 181-200.
[2] Here diagnosis is meant in its psychiatric sense, to define the mental disorder presented by the patient. It is clear that every clinical psychology intervention involves a phase of knowledge-getting, which we could also link to a diagnostic intention. The etymology of diagnosis itself is linked to a process of knowledge-getting. In the history of clinical psychology, knowledge of problems and diagnosis have often been used as equivalent terms. Every psychological intervention involves knowledge; in particular, as we shall see below, reporting has as its aim the knowledge that develops in the clinical psychology relationship. Diagnosis is therefore not an ugly word, as Rossi Monti suggests in his interesting article Rossi Monti M. (2008), Diagnosi: una brutta parola? (Diagnosis: a dirty word?), *Riv. Psicoanal.*, 56, 3, 795-803.

deficit correction, but with promoting well-being. Admittedly, but what does "health" mean, if the term refers to the psychological aspect of a single individual? Does it mean that the person has no problems? That he is happy? That he is healthy? That he is self-actualized? One might ask whether this term can be used outside the context where the person lives. Is it possible to consider "well.-being" as an aspect of the individual's disposition? On closer reflection, we discover that in our culture these terms take on a metaphorical sense when applied to a single individual as well as to an organization or an institution. Being metaphorical expressions, and therefore allusive, they do not require models and theoretical propositions to support them. They are *allusions evocative of reassuring emotions*; just as they can be evocative of anxious perturbing emotions, expressions linked to psychopathology. Some time ago, with my research group, I proposed *development* as the goal of the clinical psychology intervention, as an alternative to the *deficit*-correction intervention. The notion of development differs profoundly from that of health. Development is closely connected to the context in which it is proposed and pursued. It is a notion that envisages a psychological theory of relationships, and experimentally based models of analysis of the connection between individual and context. The development of a relationship can be observed, measured, reported on; it is possible to make a clinical psychology intervention for its implementation.

A conception of clinical psychology as intervention addressed to the individual, on the other hand, entails a simplification of the field of interest for the clinical psychologist: the psychotherapist deals with psychopathologically problematic individuals, while the health psychologist deals with "healthy" individuals, so as to facilitate and implement their well-being. Clinical psychology is in this case likened to the psychotherapy of mental disorders classified and diagnosed according to the canons of psychiatry; health psychology occupies the left-over professional space.

The name health psychology, moreover, poses a further problem.

Sergio Salvatore, in an article published in 2006 in this journal[3], talks about the theoretical weakness of psychological language and refers to two aspects in this regard: the tendency to use psychological categories in a reified manner, that is, to treat "*psychological concepts not as constructs that construe the objects of the discipline in modelistic terms, but as pieces/states/qualities of the world"* (p. 122); the second aspect concerns the definition of the objects of psychology: "*Parallel to the tendency to use psychological categories in reified terms, psychology tends to choose its objects of disciplinary interest (both on a theoretical and a professional level) from phenomena taken directly from reality. This tendency is essentially a by-product of an epistemological approach of neo-positivist inspiration, which sees the categories of scientific language as the precipitate of a controlled process of systematic organisation of experiential data*. (Salvatore, 2006, p. 123). We think that an example of this problem can be found in the name "Health psychology". It could be said that also in the expression "Clinical psychology" we are in the domain of metaphor where the disciplinary object is drawn directly from reality. But it is precisely the effort to define the theoretical and methodological connotations of the clinical psychology intervention that "liberates" clinical psychology from this impasse. This does not seem to happen in Health psychology. Let us look at an example of this.

In recent research[4], the authors wonder which activities are recognised as being typical of the psychologist. To find an answer, the authors apply factorial analysis to the responses in a questionnaire[5] about this field of enquiry.

Factorial analysis is conducted on unidentified parts of the questionnaire, which however refer to the *activities* recognised as being typical of the psychologist, as well as to *situations or contexts* in which the interviewees "would contact this professional figure". Eight factors, or "thematic dimensions" emerge. In our opinion, it is interesting to look at three of these: the area called "quality of life"; the one that "attributes the psychologist with competence above all in managing

[3] Salvatore, S. (2006). *Models of knowledge and psychological action*. *Rivista di Psicologia Clinica*, 2-3, 121-134. Available online: http://www.rivistadipsicologiaclinica.it/english/number2/Salvatore.htm

[4] Miglioretti, M. & Romano, D. (2008). La domanda di psicologia in Italia [The demand for psychology in Italy]. In Ponzio G. (ed). *La psicologia e il mercato del lavoro: una professione destinata al precariato*. Milano: FrancoAngeli.

[5] This was a questionnarie administered via the internet to 2000 Italian families (4,350 people).

states of malaise and suffering: the psychologist helps to tolerate existential malaise, the stress of living, or soothes suffering"; and lastly, that of psychotherapy.

The statements that are factorised for the first area are, briefly:

management of everyday problems; process of personal development; facilitation in being with other people; improvement of quality of life; problems at home, in the family; problems in choosing the future school or career; problems in making important life choices.

The statements in the second area are:

coping with malaise; caring for existential distress, or sickness of life; alleviating pain; getting over anxiety/distress/phobias.

The statements in the third area are:

disorder of the mind or of behavior; mental illnesses.

Since these factors are seen as not having a model of reference, authors are led to state that the first area is that of *health* psychology, the second of clinical psychology, the third of *psychotherapy*, defined as a "technical tool designed to treat mental illness and behavior disorders". Nothing could be more misleading. The distinction underlined may make sense for the members of the families interviewed; but the fact that the authors, not the interviewees, attributed the three problem areas to the three forms of psychology is, in my opinion, arbitrary and at the same time indicative of the case I am arguing.
Let us look at the "dense" words in the first group: *managing – growth – facilitate – improve – choose – future – important choices*.
In the second group, the "dense" words are: *malaise – distress – sickness – pain – anxiety/distress/phobia*.
For over a decade, as we said, my research group has been proposing and practising a form of clinical psychology designed to *promote development*, not confined to *deficit correction*. This distinction is based on theoretical models defining the components of interventions directed at individuals and at the same time at the relationship; it is based on a deeper examination of the methodology of psychological practice, and on categories of verification of this praxis.
Discovering today that there is a psychology that deals with development (health psychology) and one that corrects deficits (clinical psychology) does not seem new as far as the object of the psychological intervention is concerned; in fact, it seems unacceptable to suggest attributing competences to the two areas of psychology. It is well known that those who correct deficits deal with the *single person*, while those who promote development deal with the *relationship between individual and context*. These are very different scientific paradigms, in which an intense international scientific debate has been going on for some years.
Forcing clinical psychology into deficit correction, expecting *health* psychology to have the mission of promoting development, without offering any model that can define and conceptually organise the two areas of the psychology profession, really does seem to be a strange operation which ignores the mass of detailed knowledge currently possessed by clinical psychology[6]. To say, as the authors do, that those with a low educational level see the psychologist as being helpful, and those with an average to high educational level see him as also promoting development, does not seem to add much to the issue. The important questions are obviously others: who advocates a psychology designed to correct deficits? Who promotes this image of psychology? Who will take on the role of expanding the image of psychology as a profession that aims to promote development, and what cultures are willing to accept and use this proposal?

[6] I would like you to understand the problem inherent to a question that might seem at first glance a mere matter of terminology. The problem does not concern a defence of the area attributed to clinical psychology; what is interesting is the presence or absence of theoretical and methodological models underlying the psychological intervention; whether or not there are theoretical and methodological models present in the relationship, as the problem area that interests and involves the psychologist.

What emerges very clearly from the research we have briefly mentioned is a "prejudice" towards clinical work on the part of researchers. This prejudice leads to clinical psychology being relegated to the intervention for deficit correction, showing that it is entangled with psychotherapy, and giving health psychology a function that is even more individual-oriented but is broadly aimed at helping the single person in problems that are not defined using models consistent with the theory of the intervention. Health psychology is an area of psychology that is certainly growing in our country but that harbours strong contradictions, with scientific and pragmatic connotations that are widely differing, with a tendency for the specialist in such a field to impose his activity on that of the psychotherapy specialist.

Diagnosis for the verification of the psychotherapies

Psychodiagnostics, within Italian psychology, had its best season in the Sixties. Psychodiagnosis was carried out in schools, for orientation or in support of the teacher's activity; personality diagnosis was common in psychology consulting rooms; aptitude or personality diagnosis was practised in recruitment and staff orientation in organizations.
What has prompted the current revival of diagnosis in clinical psychology practice and research?
The answer is clear to whoever does research in the sector: the attention given in the past two decades to the verification of psychotherapy.
Let us see the conceptual premises on which verification is based; we shall briefly consider the possible theoretical and pragmatic consequences of this verification practice.

A – the separation between normality and psychopathology
In studies on the verification of the psychotherapies, it is necessary to anchor the collection of "outcomes" to some form of separation between *normality and psychopathology*. This distinction is central in carrying out research that can measure the degree of psychopathology characterising a specific person, so as to then record the variation as the outcome of the psychotherapy.
Admittedly the conceptual importance of this assumption is certainly underestimated. Verification involves the establishment of the notion of "normality"[7] in clinical psychology; this notion of normality will be juxtaposed to that of psychopathology, as the gap from normality. Let us see some examples of this. In the introduction to the book "Abnormal Psychology"[8], translated and sold in Italy under the title "Clinical Psychology[9]", the following statement appears: "Understanding why people behave in the normal, expected way is already quite difficult; it is even more difficult to understand human behavior that differs from normality" and also: "This book sets out to investigate abnormality, in the aspects belonging to the sphere of psychopathology." (p. 4). It is interesting to notice that from the very first pages of the book, normality is defined as "behaving in the expected way". That is, in the way that conforms to the expectations of the social system belonged to. Or, if you like, normality as *conformism*. This is the model of normality throughout the entire manual of the American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders - Text Revision* (DSM-IV-TR). As the reader will remember, many definitions of disorders provided in the DSM IV[10] imply a comparison between objective situations of the disturbed individual, and socially defined parameters of "normality". Phobia, for instance, is seen as a decidedly exaggerated fear of

[7] On this, see: Grasso, M. & Stampa, P. (2008). … Are we really so sure "we're not in Kansas any more"? Quantitive methods and epistemology in psychotherapy research: a critical perspective, *Rivista di Psicologia Clinica,* 1, 123-145.
[8] Kring, A.M., Davison, G.C., Neale, J.M. & Johnson, S.L. (2007). *Abnormal Psychology*. N.Y.: John Wiley & Sons Inc. Tenth Edition.
[9] It is interesting to see the nonchalance of the editors of the Italian edition, in deforming the book's title. I recall another interesting example of deformation in translation, from about ten years ago: the well-known manual by Krech, Crutchfield & Ballachey of 1962, entitled *Individual in Society*, was translated in Italy in 1972, with the title *Individuo e Società [Individual and Society]*. It may seem trivial, but on looking closer, even if it is only the title, it profoundly changes the way of representing the relationship between the individual and the social context.
[10] American Psychiatric Association (1999). *DSM – IV.* Diagnostic and Statistical Manual of Mental Disorders. Milano: Masson.

an object or a situation compared to the danger this object – or situation – may present. An obsession is defined as a thought, impulse or image experienced as intrusive and *inappropriate*, causing marked anxiety or distress. In the definition of Personality Disorder, this disorder "represents a model of inner experience and behavior that deviates markedly from the *expectations of the individual's culture,* is pervasive and inflexible, has its onset in adolescence or early adulthood, is stable over time and determines distress or impairment" (DSM IV, p. 687). The parameter of comparison, in this definition, is the *cultural situation* of which the individual is part and the expectations of people *conforming* to this model. The "expectations of the individual's culture" is a very strange expression, indicative of the reductionism of cultural dynamics to an individualism that moreover has to submit to social expectations. One may wonder, on this point, what knowledge the diagnostician can have about this cultural situation and about what the local culture expects of individuals. Is the diagnostician able to understand the differences in this cultural situation, when he is operating in Palermo, Milan or Illinois? When the diagnosis concerns a company director, a pensioner, or a Morrocan housewife? Then, as far as Paranoid Personality Disorder is concerned, it is repeatedly pointed out that the patient shows diffidence and suspicion for which there is "no *sufficient basis"*, "no *justification*"; one talks about "*unjustified* fear" or of "perception of attacks *not evident to others*" (DSM IV, p. 696).

B – Methodological rigor

A second element, closely connected to the introduction of the normality - psychopathology dichotomy, is that of *methodological rigor*, designed to bring psychotherapy itself back into mainstream "scientific-ness". Here by "scientific method" what is often meant is a procedure used in medicine to verify the *outcome of medication* on specific forms of pathology.

The confusion here is at a peak. In many works it is stressed that the "scientific" methodology does not give positive results about the verification of the outcome or the analysis of the psychotherapy process; other studies reject the more pessimistic data, showing that the results of verifications are satisfactory and credible. In the numerous methodical reviews of the subject, there are swings between optimism and pessimism, like on a rollercoaster trip.

Methodological rigor seems to coincide for many authors with the measurement of variables that make it possible to demonstrate the effects of psychotherapy or of the progress of the process that characterises it. This has entailed considerable effort to measure clinical aspects which, with current knowledge, seem difficult to use as dimensions of verification. One example comes from the still limited area of research where there is the attempt to demonstrate the effect of psychotherapy by recording the modifications in the neurobiological correlates of the individual under treatment. This is made possible by reliable technologies which enable the activity of the cerebral function to be assessed. But this recording of biological data, designed to prove the efficacy of psychotherapy, seems to ignore or underestimate two problems: the first concerns the profound modification of the psychotherapeutical setting entailed by the recording of the neurobiological correlate (especially if it is in psychodynamically-oriented psychotherapy); the second concerns a major epistemological limit: to give a "psychological" sense to the changes shown in the biological data, it is necessary to use psychological categories, thus falling into the epistemic trap deriving from the fact that the two models are non-reducible.

A second example can be found in the efforts to make a rigorous, "objective" diagnosis in the area of psychopathology. Let us think, just as an example, of the aspects assessed in the SWAP 200[11]: here 200 statements are used to make a measurement of the patient's personality; the clinician has to assess the different statements on an eight-band scale (0 – 7), in relation to the degree to which each statement can be applied to the subject to be diagnosed; it goes from zero points for the statements that the clinician considers irrelevant or inapplicable for that patient, to a score of 7, for the statements considered to closely describe the patient.

Let us look, for instance, at three statements on the scale:

- "Tends to see his/her feelings and impulses as unacceptable in others but not in himself/herself"

[11] Westen, D., Shedler, J. & Lingiardi, V. (2003), *La valutazione della personalità con la Swap-200* [Assessment of personality with Swap-200] *. (CD-ROM allegato)*. Cortina, Milano.

- “Behaves so as to arouse in others feelings similar to those he/she is feeling (e.g., when he/she is angry, he/she acts in order to provoke anger in others; when he/she is anxious, he/she acts so as to induce anxiety in others)”
- “Tends to arouse extreme reactions and strong feelings in others”

There are two limits that we can find in this assessment procedure. The first concerns the object of evaluation: one assesses episodic aspects of a person, anchored to specific relational situations, as if they were aspects of the disposition characterising that person, independently of the context of his relationships. The second concerns the connection between aspects to assess and the score proposed for the assessment: how is it possible to state that the feature “Tends to arouse extreme reactions and strong feelings in others” defines a patient, say, with the score of 3? What does that score mean? How is it different from a score of 4? But also, how can an “external”, differentiated score on the scale be given for a dimension that certainly also involves the assessor? There is therefore uncertainty about the possible use of the ordinal score for aspects of this kind, as well as uncertainty on the clinical “sense” of the statements, and therefore on their possible use, outside a specific relational situation.

Similar problems can be identified in the attempt to use “individual” parameters to measure psychological dimensions that inevitably belong to the relationship. A paradigmatic example is that of the Therapeutic Alliance, a phenomenon characterising the relational dynamics between therapist and patient and which it is claimed can be measured with scales applied to the patient on the one hand, to the therapist on the other.

In sum, the intent to pursue methodological rigor is certainly laudable; however, the paths taken to achieve this objective arouse great perplexity in the methodological sense. Such perplexity is based on long years of research and reflection in psychology on the issue of measurement.

C – Scientism

In the verification of psychotherapy, the need for the “objectivity” of the data on the effects of psychotherapy is often stressed. The attitude justifying this “objectivity” comes from the conviction that the only “scientific” method is that founded on the “objective” recording of independent data by those who, with the collection of this data, see their own action under assessment. Seeing the “objectivity” of the data recording method as being identical to the “scientific-ness” of the findings is a characteristic of what we for some time have been calling “scientism”: a sort of idealization of measurement, as a fetish of scientific-ness.

In sum, studies on the verification of psychotherapy, though creditable in posing the problem on the sense of psychotherapeutic work (for the professional practising it, as well as for the people who go to the professional), show some major limits in dealing with this issue.

These limits are important if one wants to identify psychotherapy and its verification with clinical psychology, and have the following consequences:

1 – restriction of psychotherapy to a practice merely aimed at reducing problems previously diagnosed as psychopathological. This entails the acceptance, for the sake of verification, of a drastic dichotomy between normality and psychopathology.

2 – introduction of “objective” measurements in psychotherapy.

The report

We think it is important to go back to reflecting on clinical psychology practice, on its goals, on the theory underlying intervention, on the methodology and on the important issue of verification. It is a matter of redefining the relation between problems – the theory of the technique underlying intervention on problems – techniques for verification, consistent with the theory of the technique and with the techniques used.

The problem of verifying the intervention cannot be dealt with unless the three phases of the intervention are kept in mind:

- analysis of the *problems*
- *intervention* based on the relationship

- *verification*

We think that the *report* has the role of linking the three phases of the intervention and giving sense to verification within the psychodynamic context.
The report does not need to make a demonstrative interpretation of the outcome of the intervention. Therefore it is also released from the interpretation of the process, if, as is often said, the interpretation of the process is a prelude to that of the outcome: studies on the psychotherapy process tend, in fact, to coincide with those on the outcome: the complex interaction between the variables of the process is considered a predictor of the outcome of the treatment.
But outcome and process studies seem designed to show the efficacy of the intervention to those taking the position of *third party* in relation to the intervention: the society which funds the intervention on the one hand, the scientific world on the other. With the verification of psychotherapy, in other words, one feels the need to legitimate one's psychotherapeutic action in the eyes of the skeptics. In particular, the first component (society that provides funds) is often identified with the insurance companies that pay for psychotherapy in order to solve their clients' mental health problems; or the top management of a public health service that classes psychotherapy among the medical treatments characterising the different services. Hence the need to demonstrate that the forms of psychopathology *improve* with psychotherapy. The scientific world, in particular the medical world, seems to be skeptical towards psychotherapy, due to the intrinsic difference from the medical operating style. It does not seem very fruitful to chase the support of medical culture by medicalizing psychotherapy, in the diagnosis that justifies the intervention as well as in "empirical" verification, assimilating the latter to the verification of pharmaceutical efficacy. Doing so would lead to the corruption of the theoretical and methodological foundations of psychotherapy, at least to that of psychoanalysis.
One might ask: what factors have made it possible for psychotherapy and the clinical psychology intervention to "survive" and "develop" in the past eighty years? Do we think that all this is due to the psychotherapeutic improvement of some forms of depression[12]? Or can we legitimately acknowledge that psychotherapy has developed thanks to its competence in dealing with the *problems* of people, groups and organizations; problems of adjustment and of development in the context where the people belong; problems of growth and of competence in the dynamics of social relating. These are therefore problems that, being linked to the psychiatric classification, lose the emotional depth that characterises the patient's experience and describes the process of adjustment to the context.
To confine outselves to individual experience, why does a patient come back, session after session, in psychotherapy? What factors make it possible to work for years with individual people, social groups and organisations, with no binding contract, no certificate of attendance or of skills achieved, no rules regulating the relationship, except for the conditions of the setting, and therefore the working methodology? Do we have to seek an answer to these questions in the uncertain data of outcome or process research? Is it perhaps the a-specific factors (therapeutic alliance, psychotherapist's competence, coherence with the therapy protocols) that lie beneath the "success" of psychotherapy? What is the goal of the alliance, albeit in its uncertain and manifold definition: competence or the operative protocol? It would be more useful to talk about the *objectives* of psychotherapy. Can we mechanistically sum up these objectives as the diagnosis of the psychopathological form to be treated?
Underlying these questions there is an important discriminating factor, too often neglected or ignored by those doing research to verify psychotherapy.
This is the discriminating factor that on the one hand sees a psychotherapy addressed to the individual and his disorders; on the other a psychotherapy focusing on the problems of relating between individual and context (where the person lives and belongs). The unquestioned basis of psychopathology is the individual expression of the pathogenous form. The psychotherapy we are thinking of is founded on the relationship. And it is impossible to link the relationship and the problems experienced in the relationship to the manualized classification of mental disorders. In

[12] When one lists the mental disorders that reflect either one or the other psychotherapeutic technique, reference is made to: depression, anxiety disorder, anorexia and bulimia, bipolar disorder, schizophrenia, personality disorders, post traumatic stress, alcohol abuse, substance abuse, sexual disorders.

this respect psychology differs from psychiatry, despite the fact that also in psychiatry, particularly in social psychiatry and in psychiatric epidemiology, a strictly individualistic conception of psychopathology is rightly questioned.
All of this leads to considerations that are only seemingly outside the issue of the contrast between diagnosis and report.
We are thinking of the claim of individual normality, in the sense of an a-critical conformist adjustment to the system of power permeating a particular society and a particular culture. We are thinking of psychopathology as the gap from the conformist model. Historical, sociological and anthropological studies have confirmed the vision of an individual psychopathology as an important tool of social control. The alleged "objectivity" of psychopathology is systematically disproved by the analysis of different cultures, both diachronically and synchronically. I still remember a poorly written note shown to me by a journalist friend in Palermo, at the end of the Seventies: he asked me for a diagnosis of the "psychopathological" nature of the writer and of the help he was asking from the newspaper: he wrote about invisible persecutors that terrorised him to an incredible extent. Without situating that note in a context, one might have talked about paranoid personality disorder. In actual fact, in the *definition of Personality Disorder* the latter, as we mentioned earlier, represents a models of external experience and behavior that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible, with all that follows (DSM IV). The parameter of the definition is therefore the *cultural scenario* of which the individual is part and the expectations of people *conforming* to this model. As far as Paranoid personality disorder is concerned, moreover, it repeatedly stresses diffidence and suspiciousness "without *sufficient* reason; without *justification*"; it talks about "*unjustified* fear or perception of attacks *not evident* to others" (DSM IV, p. 696). I talked to the writer of the note, and in the conversation it emerged that he was a trade unionist from a town near Palermo, who had organised trade union action not appreciated by the local mafia. There were no explicit threats. On his trips from the town to Palermo and back by public transport he was left totally alone: nobody spoke to him any more; everybody, including his friends, avoided him and he did nothing to seem approachable, accepting his solitude: a sign of abandonment as an inevitable event. How can one understand this situation, how can one grasp the problem the person was presenting to the newspaper, without knowing the context and the experience in that context? What psychotherapist can assess the extent of the "justification" of an experience of persecution? Not only because the case involves the mafia, obviously. When can we say that an experience of persecution is due to *raving*? Is it necessary to know this, before undertaking psychotherapy? Or does the diagnosis of Paranoid Personality Disorder hinder the relationship between the person making the diagnosis and taking a therapeutic role, and the person presenting his problems in psychotherapy? In the case just described, I talked at length with the trade unionist, with very different aims from that of treating a personality disorder.
It seems clear, though it may be difficult to accept, that psychotherapy designed to *improve the psychopathological state* is radically different from psychotherapy that sets out to *facilitate thinking about the emotions experienced in the relationship,* starting from the psychotherapeutic relationship.
It would be interesting to make a study analysing the direct or indirect prescription of conformism inherent in the Diagnostic and Statistical Manual of Mental Disorders. It is significant to see that when "normality" is regulated by prescriptions or conformist definitions, then psychopathology is configured as a gap between this and the regulation model: this gap from the model does not concern the relationship with the context, and therefore the dynamics of adjustment between person and context, as much as some of the characteristics of the individual's disposition. Starting from this premise, the psychotherapist's function is inevitably to reduce the distance from the norm and as far as possible to restore the conformist position. This is regardless of the history, the experiences of the person presenting the problem to the psychologist, but above all regardless of the problem the person has experienced. This problem has to be transformed, thanks to diagnostic scales and tools, into a disorder to be improved. It is understandable that the diagnostic option is welcomed by psychologists, especially those who study or practise psychology without any professional models, and without reflection on the psychologist's role. The fact that the diagnostic tool can be applied mechanically, without the slightest reflection on what one is doing, but with the illusion that one is "making a diagnosis" and assuming for a few hours the status of a doctor, may attract many to this practice, often practised with no sense at all.

If one looks at the *problem*, the psychologist's task becomes far more taxing and complex.

Emotional involvement

First of all it is a matter of being able to experience the emotional involvement that the relationship with the other person entails. Being able to experience one's own involvement and that of the other person, means understanding the connection *between facts and emotions,* in what the other person presents as a problem, but also in the emotionally involved relationship with him/her. This ability to grasp the connection between facts and emotions, between events and the fantasies aroused by the events, is a great obstacle for psychologists. I say "for psychologists", because clinical psychology is the only profession that requires this competence. I believe it is the fundamental competence in clinical psychology work. Let me give an example:

A patient who lives in Rome has a very ill mother; this prevents her from going to her own daughters' place in Bari and spending time with her adored granddaughters. The patient arrives furious at a session, saying that she is going to break off relations with her daughter: she can no longer put up with the fact that her daughter often comes to Rome for work and does not bring her daughters to her place; she leaves them with her parents-in-law in Bari. The latter can thus spend far more time than she can with the granddaughters. She wants me to side with her and say she is right in this legitimate complaint against her daughter.

It should be pointed out that the patient has been coming to analysis for a long time, has established a trusting relationship with the analyst and knows, from past experience, that when she feels intensely involved in an attack of anger, "there's trouble brewing".
To understand the situation, it should also be added that for many years, since she was born, the daughter had lived with her mother who, when the child was born, split up with a difficult partner that could not stand having a child in his life. The patient has acted "as mother and father" for the daughter, with great apprehension about the daughter's ability "to get by in life". Years earlier, the woman started therapy in an attempt to understand something more about the bond with her daughter. The patient is now married, has had a daughter from her present marriage and leads a professionally and affectively satisfying life. Her daughter is also married; she has two daughters and a husband who loves her very much; she has established her competence in her career, though not in a traditional field, and has for some time been having considerable success.
The emotions the patient brings to the session are anger with her daughter who "takes away" her granddaughters; envy and jealousy for the girl's in-laws who enjoy the grandchildren, while she doesn't; vexation with the daughter's achievement of autonomy, which the patient sees as an abandonment (the daughter has recently announced that she will spend the holidays with "her" family and not with her mother).
What was the "trigger"?
A stolid alliance with the patient would lead one to say that the daughter neglects her mother, "after all she's done for her", in favor of the parents-in-law, and so on. There is no end to this kind of meaningful common sense. I stress all this because the aspiration of building a reassuring, winking alliance with the patient can lead the psychologist to reel off the most inventive varieties of nonsense, to preach, to rend his garments in the name of the injustice suffered by the patient, in the hope that this will reinforce the alliance.
Seemingly, on the other hand, the "pivotal" event is the patient's difficulty in going to Bari to see the granddaughters, since she has to stay in Rome to take care of her mother.
The real event, closely connected to the associated emotions, is *not having told* the daughter this; *not having asked* whether, in the meanwhile, she could bring her daughters with her to Rome, where she often comes for work. Not telling and not asking: these are not "events" capable of organising the psychological thought as a cause and effect relationship between a fact and the emotions that that fact necessarily evokes (at least in "the expectations of the individual's culture" which was discussed a few sections ago).
Why is the patient unable to tell and to ask her daughter? The history of the relationship between the two helps us to understand: the patient was forced to take on a severe parental role, strict and sure of herself. The patient thought she could bring up her daughter "without a father", and with an

overpowering social hostility, only by adopting such behavior. In her way of representing this difficult task to herself, this meant never letting her fragility show, or giving away her desires. This meant never asking the daughter for anything, at any time in her life. The patient had to prove she was "a strong woman", with no failings, who never had to depend on others. This was useful to her in her affective and professional life. But it was also a weight. Perhaps the first time she was able to ask for something, after a great struggle, was in analysis. Now her daughter is successful in her life and career; the patient finds her life conditioned by her mother's state of health, and she feels the strong desire to be with her granddaughters. All this depends on asking her daughter to notice her difficulties and her wants, but her daughter is not used to thinking of her mother as someone who "needs her". And the mother does not want to lower herself to ask. She prefers to break off her relations with her daughter, let unleash her rage against the in-laws, think that nobody respects her and gives her what she deserves, instead of communicating. Are we talking about facts or emotions? Obviously, in this reconstruction, facts cannot be distinguished from emotions. "Facts are facts", with whatever that entails, is a stereotype that does not work in clinical psychology.
The belief that emotions descend from facts, and that they are justified by the facts, is hard to get rid of in the psychologists' relational mind. When emotions descend from facts, the psychological function can be seen as leading the patients back to "the facts", to recognising the facts and acknowledging them. Otherwise your "wrists will be slapped". The psychodynamic reconstruction of a complex life experience is far more difficult than being called back to the facts. Which anyway, due to conformist beliefs, translates into being called back "into line". This playing the role of the preacher, a mixture of spiritual guide and police-officer, giving rise to the unleashing of conformist good sense, can transform the psychological role into an anachronistic recital, offensive because it is pointlessly arrogant[13].
If the diagnosis – therapy – verification procedure claims to work on the "facts", the praxis of clinical psychological intervention and report sets out to give a sense to the events and to the emotions indissolubly intertwined with them.

The elaboration of categories

It is also a question of *elaborating categories* that enable the psychologist to grasp the sense of what is experienced in the professional relationship. These categories concern problems, in the double connection of the *there and then* that lies beneath the request for psychological intervention and of the *here and now* of the relationship with the psychologist. I hope it is clear that the problems of the there and then are not the psychopathological problems of the individual. Not even if they are seen from the point of view of his clinical history, starting from earliest childhood or from the attachment style handed down through the generations to the patient's mother. The person who goes to the psychologist does so in most cases because he is experiencing a problem that causes "distress", feelings of "impotence", "failure", difficulty of "adjusting",of "intolerance" towards specific aspects of his own existence. The motivation to go to the psychologist, which I have summed up here in to a few specific components, are the most varied. One can talk about "distress"[14] as an emotion that motivates the recourse to a psychologist, but to say that the psychologist deals with "distress" (psychic, obviously) is like saying that the physician deals with people that are sick and the restaurateur deals with people that are very hungry. *Ça va sans dire*! To say that the psychologist deals with distress means avoiding a categorial definition of the problems people bring to the psychologist and avoiding their symbolic categorization, in the demand. It must be underlined that the search for problems does not finish with the "diagnosis of the problem"; exemplary of this are statements like "that woman has a problem with the mother figure" (whoever is without sin, cast the first stone) or "that man has problems of insecurity" and so

[13] I recall an old university student, who was scandalized at the suggestion that facts and emotions were closely linked and that emotions were important in facts; sitting on a seat in the group therapy room, beating his fists on the arms of the chair, he kept saying angrily, "no, it's not like that, facts are facts! These for example are not emotions; they are chair-arms!"
[14] The Italian term "disagio" (malaise) derives from Latin *dis iaceo,* which means: feeling far-off; it implies an emotion of separation, of being far away, and it is therefore an emotion that is explicitly connected to the relationship.

on with the banalities. No. Categorising the problem implies reconstructing the process that the person is experiencing in relating to the psychologist, and the close connection between this relational dynamic and what is narrated in the there and then. The problem that is presented to the psychologist has two sides: one "experienced" by the person making the demand and the other present in the "translation" that the psychologist necessarily makes of the problem experienced. The relationship with the psychologist works as a mediator between the problem "experienced" and the problem "translated".

Let me explain this with an example.

A psychologist goes to the psychotherapist because he is unable to control his emotions in his professional relations with his own patients. In particular he is unable to control his fantasies and his acting out when he is dealing with female patients who, in the psychotherapeutic work, adopt seductive attitudes and behavior. The psychologist thinks that if this continues, he will fail in his profession and will get himself into trouble. But he also feels that the propensity to act out is "stronger than himself". This patient/psychologist will try in all possible ways to drag his psychotherapist into acted out dynamics: only in this way will he be able to convince himself that "it's the same the world over", that even those cloaked in competence and science in the end are as weak and fragile as himself. In fact, when he acts as judge of the weaknesses of others, he emerges as being stronger than the next man. It is with this perverse plan that the patient/psychologist approaches the psychotherapy relationship, hoping to find facts that bear out his expectations. And he finds his facts: it is enough to mix facts with fantasies to convince himself that things are as he expected. An episode? The patient/psychologist talks about his relationship with his wife and recalls that he is going away on holiday with her for a weekend in a month's time. When the week before the said weekend arrives, the psychotherapist asks him to come to a session on the Friday, telling him clearly that the decision is up to the patient. The latter looks at him amazed and says: "but it's my long weekend!". The therapist replies: "taking a weekend off is a choice made by people, it is not a consensual event like an official public holiday". The patient/psychologist gets angry, and furiously accuses the therapist of not caring about him and the things he says: he aggressively reminds him that he had announced his "long weekend" and thinks that the therapist is worse than him: when he molests the patients he does it out of love, while the therapist shows only indifference and irritation towards him. He is filled with emotions that he feels are justified and legitimate, because they are based on specific facts. Just as it is a fact that when a pretty patient crosses her legs, this is a clear sign of sexual provocation. Only a difficult process of distinguishing between facts and emotions, to see then how the fact had evoked emotions that had been confused with facts, enables the patient to understand, at least in part, the perverse aspect of his therapeutic plan.

Another example comes from the complex interpretation of a dream.

This was a man of about forty, married with no children, a successful professional in a large town in Lazio. This person came to analysis because he feels there are problems in his affective life: though deeply in love with his wife with whom he shares the family and professional life, he has not had sex with her for some years. For him this is not important, since affection and love have not disappeared with the absence of sex; in fact, he feels they have been strengthened. His wife, however, shows signs of impatience; it seems that she has fallen in love with another person, and she wants a separation, while continuing to work together professionally. The man is frightened by the idea of separation, although in a sense he feels it is inevitable. He comes to analysis to face up to this confused and painful situation.
After a few months of analysis he has the following dream:

"I'm in the street, I see a beautiful woman and I'm sexually attracted to her; the woman is indefinite, faceless. While I realise that I'm attracted, I see my wife passing by, staring into space; I hope she will look at me, but she passes close by without giving any sign of recognising me and disappears into the distance."

Matte Blanco talks about the mind's unconscious mode of being as a "homogeneous and indivisible" modality: a modality that logically follows from the principle of *generalization* and from that of *symmetry* through which the unconscious mind deals with the elements of reality. At the same time, he talks about a "heterogenic-dividing" modality[15] as regards the mind that generates

[15] It has been pointed out various times that the two expressions used by Matte Blanco are intrinsically different: in the "heterogenic-dividing" modality what is indicated is an action and a process modulated in time: there is an act of division,

scientific thought, where the function of the mind is principally that of establishing relations between aspects of reality.
Let us look at the dream. It should be remembered however that our written *version* of the dream in this article and the patient's *narration* of the dream come about with the mediation of language. It is a language expressed in a narrative sense, and therefore in a heterogenic-dividing modality. This is the first problem, from the clinical point of view. Not from the theoretical modelistic point of view. It is in fact established and accepted that, in order to talk about the theory of the unconscious, one uses scientific thinking, which underpins relationships and establishes dividing bonds between the various aspects of the theory. It is thus agreed to talk about the unconscious in a symbolic universe that does not belong to the unconscious, and which "thinks about" what happens in the unconscious dynamic. It is agreed, therefore, to establish a relation between what happens in the unconscious system and what we say "about the unconscious", starting from heterogenic-dividing thought. But let us get back to the clinical aspect: the clinic of the unconscious. Admittedly, it is not possible to talk about the dream, to interpret it and to use the interpretation in the practice of psychoanalysis, without using language. This is the paradoxical problem, at least on the surface: one can use "unconscious" clinical material, domesticating it into a language made to establish relations within the practice of interpretation, based on the relationship between patient and psychotherapist. This is possible if however some directions are followed, taken from the theory of the unconscious. One solution may be not to treat the dream as a "story", that is, as an organized narration with a meaning deriving from its insertion in time and space. Instead, the dream can be looked at by using the dense words[16] hat occur throughout it. We therefore have a sequence of the type: woman – street – beautiful – indefinite – sexual attraction. And also: close by – wife – pass by – staring into space– non recognition – distance.
We could think of the contrast between the "street woman" who attracts and the "wife" who passes, and disappears into the distance…. perhaps she passes into another life. Another contrast is that between the woman-that-attracts as in "life" and the wife-that-disappears into the distance as in "death".

---

of differentiation, which gives rise to heterogeneity among the elements of reality that will later be placed in relation to each other. In the "homogeneous and indivisible" modality, on the other hand, what is indicated is a state without a process of becoming; this modality, like quicksand, seems to attract and swallow up whatever comes into contact with it.

[16] See in this respect: Carli, R. & Paniccia, R.M. (2002), *Analisi Emozionale del Testo. Uno strumento per leggere testi e discorsi* [The Emotional analysis of the text. An instrument for reading texts and discourse], FrancoAngeli, Milano. By 'dense words' we mean the components of a text (written or spoken) that have maximum polysemy and minimum ambiguity. We know that words are divided into two broad categories when seen from the clinical psychology point of view: dense words (*high polysemy and low ambiguity*) and non-dense words (*low polysemy and high ambiguity*). The second kind acquire meaning in a language context; they therefore evoke a low "emotional symbolization". An example is the word "go": go home, go well, go for a walk, go and not come back. The word acquires symbolically different meanings, if it is part of different language contexts. It is an ambiguous word, which takes a sense only from the language context of which it is part; it is therefore a word that, if taken in itself, denotes low polysemy: the emotional evocation is closely connected to the language context. If on the other hand we consider the words "go away", as a single specific language expression, then this evokes a great, dense emotionality. This applies, consistent with the "density" of the expression "go away", which can be evoked and experienced in an involving way, independent of the language context where the expression is found. Let us now think of the word "bomb": the emotional dynamic evoked is again very strong and tends to be univocal in its affective sense (evoking destruction, sudden explosion, desertification of a place, disaster, death, things and people torn apart …and so on *ad infinitum*), again independent of the language context of which it is part. Returning to our example of evaluation, the words used are all dense words: trust, usefulness, knowledge, desire. Each of them evokes infinite associations of meaning, in their polysemy. If we wanted to use these dense words, and he evaluations connected to them, to understand something about what the evaluators think of the psychologist, we would have to resort to the notion of *reduction of polysemy* entailed in the meeting with dense words.
It is interesting to notice that Freud dealt with a similar theme in his work on the uncanny [Freud S (1919), The uncanny, OSF, 9, 77-118]. See the analysis conducted in this work on the word *Unheimlich* and of the "opposite" term *Heimlich*: the ambiguity of the terms means that the second can coincide with the first, even though it is its opposite.

Let us consider the word “indefinite”, used to describe the alluring woman: *finis* is the boundary, the limit, with the reinforcement of *de;* the negation of what is definite, of what has a limit, a boundary, involves the lack of a precise figure or a face with a recognizable shape. This recalls the impossibility of defining, or of giving a face to the woman that attracts, and therefore of being attracted to a precise woman, endowed with an identity that allows a relationship of attraction, or if you like, a sexual relationship. But the converse is also true: due to the principle of symmetry, the man who is attracted to an indefinite woman, is also the indefinite woman that is attracted by the dreaming man. While attraction means “be brought towards” from the Latin *ad trahere,* the indefinite blocks the direction of ‘being brought’: the indefiniteness makes attraction fail, it makes it impossible. The woman in the street, on the other hand, is indefinite and makes attraction impossible: think of the illusion of a relationship with a prostitute, a woman one cannot possess and who does not give herself unless it is in the situation of prostitution, with no participation, no reciprocity, without responding with any possible attraction. In the symmetrical, the woman is attracted by the man, but in this case it is the man that does not give himself, who cannot reciprocate the attraction, who does not know how to have a sexual relationship based on reciprocity. In both situations, of the impossible woman and the impossible self, the man cannot have a relationship outside the relationship with his wife, that is, outside, “in the street”. He can, however, hope for a exchange of glances with his wife “who passes by” and disappears into the distance. This means a wife who has passed into another life as far as sex is concerned. She can reciprocate the gaze of one who does not come up to her, but at the same time she is already close, being tied to him by the bond of marriage.
Let us look at the term “without recognising me”: the non recognition. Re-cognise (from the Latin *re-cognosco*) means knowing a second time, and implies meta knowledge; if you like, a reciprocity as the outcome of second order knowledge in a relationship. The dead woman, therefore, is dead because there is no possibility of recognising, and therefore of reciprocating the man’s emotions and affects. But according to the principle of symmetry, the converse is also true: it is the man that does not recognise his wife, he does not let her live sexually and emotionally.
In sum, the man seems to be split between the *two female figures of impotence*: impotence towards a woman who is attractive because she is indefinite, towards the wife because she is dead, in relationships where there is no possibility of reciprocity. At the same time, he communicates that his sexual desire has been revived, albeit for the woman in the street, the woman who is indefinite and therefore impossible.
It is clear that the dream has endless meanings, if by ‘meaning’ we are referring to the translation of the emotional dream message into communicable common parlance
It is up to the psychotherapist to use the dream meanings that are most useful for the patient in the understanding of his current emotional dynamics. This leads to the third point of this survey.

Intervention strategies

Finally, it is a matter of identifying the most suitable *intervention strategies* for the relational situation. This is one of the issues that receives the least attention in training and scientific debate in the area of clinical psychology. The reason lies in the fact that the modes of intervention are “immersed” in the emotionality of the relationship, and thus cannot be reproduced. I recall, and this is a trivial example, the plenary session of a 9-day group seminar, lead by a French trainer with Italian assistants. It was a plenary that began with a silence that went on for minutes, and the emotionality of the thirty-odd people present became more and more overpowering. One of the trainers broke the silence and said: «On est en train de veiller un mort». That intervention had an immediate cathartic effect: many people were crying, others started talking about the group’s emotional moment, others expressed great apprehension in their faces and their gazes. Eventually, a participant said that he felt alive thanks to the group, and this utterance was the jumping-off point for an elaboration of the grief evoked by the fusionality of the small group and of the groups in the plenary; it was a feeling of plunging into a state of non existence. The strange thing was that, in other seminars, when someone tried to repeat the intervention during the silence of the plenaries, all he aroused was derision.
“Interventions” cannot be repeated, either in groups or in psychotherapy.

What is communicated in clinical psychology work is necessarily connected to what is understood in the relationship, to what is believed can facilitate emotional thinking in the relationship itself. Hence the personal style, the high correlation between what is communicated and the emotional dynamics with which the communication comes about, the capacity to understand the other or others, the feeling that what is said will be taken in so much by the other person that he will forget that it was a psychologist speaking. When a good intervention is made, the other person often assimilates what has been said to the point where all that remains in his memory is the belief that he himself thought of the things the clinical psychologist was communicating.
The intervention strategies, on the other hand, are connected to the dynamics of the relationship and to the ability to monitor the progress in being able to 'think emotions' both in the person working with the psychologist and in the psychologist himself.

The function of the report

How does one report all this?
And why does one make a report?
We were saying above that psychotherapy does not need to prove its efficacy to anyone, if the "demonstration" serves to legitimate its existence. Years of psychotherapeutic practice are worth more than a thousand verifications. But above all, the verification does not serve to make the efficacy of psychotherapy public. Just as nobody "sees" the efficacy of oncological treatment or the economic intervention regulating inflation, here what counts is the reliability of the research and of the theories underlying the praxis. If the results are not very encouraging, this does not mean one will not continue with the research and the theoretical proposal on which the praxis is based. The activity of verification therefore is important and useful; but it should contribute to a more and more detailed understanding of what happens in the psychotherapeutical relationship, not influence this activity to make it serve the methodological requirements of the research.
Another element concerns the goal of the report. There are reports that serve to examine in greater depth the theory of intervention. But there are reports that also serve to make an in-depth analysis of the single case, to give meaning to the single interventions. This is an important point in grasping the difference between the various reports. Therefore: there are *reports designed to prove a theory through experience,* but also *reports that use theories to express an experience little by little as it unfolds.* Reports may serve themselves, the other person or the scientific community, as I said some time ago (Carli, 2007). The important thing is that the report goes beyond the emotional experience of the clinical psychology relationship, to make sense of the experience itself. The report, in other words, differentiates the common relational experience from that characterising the psychological intervention. Without a report, relationships assume an "experienced" connotation, where what happens and is acted out in the relationship is an end in itself, they do not go beyond the experience. In this sense what is called "experiential" has no clinical psychological value; experience, without reflection on experience, does not lead to an understanding of the experiential dynamics.
In this sense, the report does not correspond fully to what we are used to considering a text describing and talking about the clinical experience. It does not correspond, that is, to the dimension that in English is called a report. The report, in the meaning that I am suggesting, takes shape in thinking the emotions and in communicating this thought in the relationship; then in summing up what happens in this process. Reporting is therefore at the opposite extreme from applying techniques. One cannot report the "prescription of the symptom" insofar as the technique is reported in itself: it is enough to indicate the technique used, and everything is clear. The application of techniques is in this sense reassuring: all that is required is to choose the right moment and follow the correct technical instructions. Reporting, however, implies a theory of the technique that is never repetitive, that involves a process of thinking about the relationship that one is experiencing, therefore the uncertainty of the unknown that one may or may not understand. The application of techniques is quick and reassuring, because it creates the reality of the relationship and it makes it predictable; reporting involves waiting, venturing into unknown dimensions, trying to understand what is happening in an unpredictable relationship.

Reporting, therefore means letting the relationship exist, from a clinical psychology point of view. It means letting the other person exist, involving him in the process of psychological intervention, helping him to think his own emotions and therefore to report himself. In reporting one pursues the prospect of the other's development, and at the same time a policy of valorization of the other person. Reporting is a prelude to the other person's emancipation from dependence on the psychologist. Reporting means bringing into question the power dynamics "of one over the other" that the relational symbolization of the psychologist, "clinician" or "therapist", can entail. Reporting is synonymous with "thinking in relations". To start from the thought that follows the cardinal question of the clinical psychology praxis, "what is happening at this moment in this relationship?". This is a question that all clinical psychologists are invited to ask themselves, systematically in their activity. Asking oneself "what is happening?" means activating thought about the emotions experienced, within the history of the relationship. The first report is therefore a hypothetical meaning of the emotions that the relationship enables the other person and oneself to experience. When this hypothetical meaning is communicated, this is the report for the other person, taking the form of interpretation, or of intervention designed to stimulate the other person to think and produce hypotheses. One's own report is therefore followed by the other person's report. In the clinical psychology relationship, the report can take the most varied forms: from notes to interpretation, from the reconstruction of the history of a relationship to a written summary to be used as a record of the work carried out. It can also take the form of the report addressed to the scientific community, for instance with the aim of describing the new advances in a theory, an intervention in a specific context, or a new proposal for a clinical approach to specific problems.

Hence the importance of the report in the training of a clinical psychologist. In training, the report takes on the value of the competence to see one's own limits, to never take anything for granted in the symbolic dynamics characterising relationships, both those in learning and in the profession. This is the why the new programme of the "Intervention" Degree Course, which is starting in the 2008-2009 academic year, contains a course on "Theories and Techniques of the report in clinical psychology" and a "Reporting workshop".

Reporting means examining oneself in every phase of one's professional work, looking for categories and models to make sense of events and experiences that could be resolved simply in the emotional involvement in the relationship. This is why we have introduced the report in psychology training: the report of one's training experience, and therefore the acquisition of the competence to think about training, throwing off passivity or reactivity and the a-critical acceptance of ideas and models. Reporting enables the training experience to be compared to one's own expectations, to one's professional development, and to the pragmatic benefits of the path one has taken to acquire competence.

The report historicises clinical psychological events. It places them within specific contexts. Without a reading of the context it is impossible to report. I once suggested the slogan "knowing in order to intervene", as a definition of the clinical psychology intervention, where knowledge of the context was the necessary condition to be able to understand and redefine the problems people brought to the psychologist. Without specific knowledge of the cultural models characterising a context, it is difficult to intervene in that context. It is not possible to intervene psychologically in schools, health, firms, the third sector, the armed forces, or religious structures without a profound analysis of the cultural models or of the Local Cultures governing relationships within these structures.

By Local Cultures, we mean the collusive emotional symbolization of specific "objects" of reality, on the part of people sharing a specific context. An example is the representation of the psychology profession and of its function among the population of the Tuscan Region; the representation of Mental Health Centers and their functions among the professional population working in these centers; the image of the Psychology Faculty of Rome's Sapienza University among the population of San Lorenzo (St. Lawrence), the Roman neighbourhood where the Faculty is located[17]. Identifying the Local Culture is possible and useful in many other situations, where it can give information and guide lines for the clinical psychology intervention. The idea of Local Culture sees a meeting of the theory of the *emotional symbolization* of specific objects and that of *context,*

[17] Carli, R. & Pagano, P. (eds). (2008) *San Lorenzo. La cultura del quartiere e i rapporti con psicologia* [San Lorenzo. Culture of neighborhood and the relationships with psychology]. Kappa, Roma.

constructs that can define both the objects that are to be studied as well as their collusive symbolization. In the example of the psychology demand in Tuscany[18], as we said, the object of the collusive dynamics being analysed is psychology and the psychology profession, in the way they are symbolised by the Tuscan population. It is a matter of studying the demand and the expectations that the Tuscan population make of psychologists and their profession. It is also a matter of placing the elements characterising the demand for psychology in dimensions that make sense of the demand itself and that explain any possible differences. We are thinking of the population participating in the research, and of the illustrative variables that characterise it: age groups, sex, place of origin, occupational areas. We are also thinking of the emergence of different attitudes towards psychology: for instance the *acceptance* or *rejection* of this profession, just to mention the extremes of such attitudes. Now, just by considering the illustrative variables alone, we might find (just as an example) that young women, housewives, residents in Prato and Lucca, accept the psychology profession, while elderly men, pensioners and residents in Siena reject psychologists and their professional presence. What information might we draw from this finding? Very very little. In fact, we would not have any explanatory element for the phenomenon identified: we could not formulate any hypothesis on the reasons for the acceptance or rejection by those specific sectors of the Tuscan population. This is for a simple, and obvious, reason: in the theories underlying studies on the psychology profession, there is no hypothesis about the connection between acceptance-rejection of the profession and the illustrative variables that we have just mentioned. There are no hypotheses on the connection between acceptance-rejection of psychologists and the fact of being men or women, belonging to a specific age group, or residing in Lucca rather than Siena. Once the data has been collected, we could certainly hypothesise a connection between the acceptance by young women and the rejection by elderly men; but they would be *hypotheses founded more on the stereotype present in the researcher than on an interpretation of the information deriving from the data*[19]. Unfortunately, research on the same subject is published, entailing a prejudicial reading of the results, in an *post hoc* interpretation of the data collected without reference models and without a theory on which to base the findings. To record the Local Cultures a greater degree of complexity is needed in studying attitudes and the cultures they give rise to. Opinions, assessments of objects, and their emotional symbolization are aspects that never refer to one single aspect of reality; and they are never the characteristics of one single person.

Multiplicity of objects and multiplicity of people: these are the elements that organise a Local Culture.

The report is therefore a form of research in psychology. It requires research models designed to ground the intervention and to give meaning to the relationships in the intervention. Without a theory of relationships and of their contextual historicization, it is difficult to link what happens in relationships, both in therapy and those of interventions in organizations, to purely individual features.

Reporting therefore also means relativising the processes of understanding relationships. This is the importance of the stereoscopic vision of the psychological report: from the most basic models, polysemy, the unconscious system, the primitive symbolizations of the world in relation to the friend/foe schema and in relation to one's body (inside/out; tall/short; in front/behind), on and on up to the historical and contextual dimensions of the culture in which one is intervening. Without reporting, theories are not integrated with the praxis; without theories, on the other hand, it is not possible to report.

An example? It is stated on all sides that the contexts where the "right-wing" culture prevails tend to see one component of this culture as privileged, that is, the individual connotation of mental

[18]Carli, R., Paniccia, R.M., Bucci, F. & Dolcetti F. (2008), *La domanda nei confronti della psicologia e l'immagine dello psicologo nella popolazione toscana [The demand towards the psychology and the image of the psychologist in the Tuscany population]*. Research report by the 'Studio di Psicosociologia' for the Order of Psychologists of the Tuscan Region, Roma.

[19]We wish to stress this point. Much research seeks "data", with no hypotheses on the models underlying the collection tools and their meaning. The data is then "explained" in terms of the common mentality, or using stereotypes present in the researcher's own culture. Such research is often useless, and at times dangerous because of its claim to experimentally "demonstrate" the prejudices of the experimenter. We mentioned one example of this kind of research in the previous section of this article

disorders with the related diagnosis and therapy; in contexts where the prevailing culture is “left-wing”, then culturalist models are successful, based on the relation between the individual and the context. This point may help to understand the terms of the contrast between diagnosis and report. This is possible, on the other hand, only if one adopts a culturalist viewpoint. If, however, one persists with a scientist vision, then the debate will shift to the reliability and the scientific rigor of the data collected to prove the efficacy of the intervention. The search for “scientific-ness” will lower researchers’ critical horizons, making it impossible for them to understand the cultural and political sense of their “preoccupation”.

References

American Psychiatric Association (1994). *Diagnostic and statistical manual of mental disorders*. (4th ed). (Ital.trans. *DSM-IV*, Masson, Milano, 1999).

Carli, R. (2007). Notes on the report. *Rivista di Psicologia Clinica*, *2*, 181-200. Retrieved from: http://www.rivistadipsicologiaclinica.it/english/number2_07/Carli.htm

Carli, R., & Paniccia, R.M. (2002). *L'Analisi Emozionale del Testo: Uno strumento psicologico per leggere testi e discorsi* [The Emotional Analysis of the Text: an instrument for reading texts and discourse]. Milano: FrancoAngeli.

Carli, R., & Pagano, P. (eds.) (2008). *San Lorenzo. La cultura del quartiere e i rapporti con psicologia* [San Lorenzo. Culture of neighborhood and the relationships with psychology]. Roma: Kappa.

Carli, R., Paniccia, R.M., Bucci, F., & Dolcetti, F. (2008). *La domanda nei confronti della psicologia e l’immagine dello psicologo nella popolazione toscana* [The demand for psychology and the image of psychologists among Tuscan population]. Rapporto di ricerca dello Studio di Psicosociologia per l’Ordine degli Psicologi della Regione Toscana. Firenze: Ordine degli Psicologi della Toscana.

Freud, S. (1919), *Das Unheimliche* [Perturbing] SE XVII, 219-252. [Ital.trans. *Il perturbante*, OSF, 9, 77-118-The uncanny].

Grasso, M., & Stampa, P. (2008). … Are we so sure “we’re not in Kansas any more”? Quantitative methods and epistemology of psychotherapy research: a critical perspective, *Rivista di Psicologia Clinica, 1*, 123-145. Retrieved from: http://www.rivistadipsicologiaclinica.it/english/number1_08/Grasso_Stampa.htm.

Krech, D., Crutchfield, R.S. & Ballachey, E.L. (1962). *Individual in Society: A textbook of Social Psychology*, NewYork: McGraw – Hill. [Ital.trans. *Individuo e Società*, Giunti Barbera, Firenze, 1972].

Kring, A.M., Davison, G.C., Neale, J.M. & Johnson, S. L. (2007). *Abnormal Psychology*, NewYork: John Wiley & Sons Inc., Tenth Edition [Ital.trans. *Psicologia Clinica*, Zanichelli, Bologna, 2008].

Miglioretti, M., & Romano, D. (2008). La domanda di psicologia in Italia [The demand of psychology in Italy]. In G. Ponzio (ed.), *La psicologia e il mercato del lavoro: una professione destinata al precariato?* Ordine degli psicologi del Lazio. Milano: FrancoAngeli.

Rossi Monti, M. (2008). Diagnosi: una brutta parola? [Diagnosis: an ugly word?]. *Rivista di Psicoanalisi*, *56* (3), 795-803.

Salvatore, S. (2006). Models of knowledge and psychological action, *Rivista di Psicologia Clinica*, *2-3*, 121-134. Retrieved from: http://www.rivistadipsicologiaclinica.it/english/number2/Salvatore.htm.

Westen, D., Shedler, J. & Lingiardi, V. (2003). *La valutazione della personalità con la Swap-200* [Assessment of personality with Swap-200]. (CD-ROM attached). Milano: Cortina.