The contribution of the health service demand in constructing psychologists' professional identity.

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Abstract

In reconstructing the roots of psychologists' professional identity, two questions are posed dialectically: 1) what demand has public health made on psychologists since the Reform of 1978 (Law 833)? 2) How has the psychology profession treated that demand? It is hypothesised that the decentralisation of health services triggered by the great reform and the affirmation of principles embodying a cultural turning point based on the complex and troubled establishment of locally based services in Italy, has had great importance in the construction of psychologists' professional identity.

Key words: identity; Health Reform; decentralisation; demand.

In clinical practice the demand almost always originates in a conflict. This may be conflict between one's experiences and conformistic expectations, it may emerge from collusive failures at various levels, in the family and in the social realm. The psychological intervention, in the sense we want to study it, makes this demand the basis of its theory of technique. Adopting it and working on it for its development is the method and the result of the intervention. After this process the participants in the process are transformed: the clinicians and their patients, the staff and their clients, the professionals and their clients, the organisations where these processes take place.
The fact that this happens does not mean that we are aware of it; quite the opposite. Taking it to extremes, it can be said that what grounds the most resistant/stable/identifying part of the *identity* is precisely what has been worked on least in the demand that parents pose to their children when they give birth to them, that patients pose to the person treating them, that distress or need for social change poses to its interpreters (social figures of various kinds, politicians, staff, social groups…). But on this complex state of the identity we have Renzo Carli's contribution to refer to.

My contribution to the reconstruction of the roots of psychologists' professional identity sets out to show the processes of "demand", largely not listened to, implemented by the public health system over the years, that from 1970 to 2000 included the implementation of its great reform (833), with special attention to the establishment of locally based services, one of which was the creation of Departments of Mental Health. The psychology profession was more or less explicitly called on to deal with these demands. As I said before, the effects of this meeting between social demand and psychological intervention remain in the psychology profession's heritage of identity, both when it was a meeting promoting growth and when it was a "failed" meeting.
I will proceed by looking at salient points, when possible anchoring them to a chronology, as in the style of the day, to provide reconstructions of the profession – which others can do better than me – with some suggestions based on my thirty years' experience as a participant in building the public health system. I will try to sketch out an answer to a question that can be summed up thus: "*what has the public health system asked of psychologists?"*
Let us start by recalling the principles recognised by our Constitution that underlie the great reform of Italian health care, law 833/1978, guaranteeing the *right to health*–along with the *principle of the equality of all citizens*. We are talking about them because they are the foundation of the social

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mandate of public health and therefore the primary organising principles of its mission. What was the destiny of these two principles when the reform was implemented? What was the stance of the psychology sector, in particular in the locally based services, in relation to these aspects of the social mandate?
Health care as a fundamental right of the individual and in the interests of the community is envisaged by article 32 of the Constitution. Today we know the cultural context of "health" to which this affirmation of citizens' rights belongs. In the centuries of modernity, as Foucault (1963-1969) tells us, medical discourse pervaded our culture, providing and at the same time imposing the imprint of its logic on issues vital to man, intervening on birth, death, pleasure, in a word, producing a *medicalisation* of life. We can explain the matter as follows: the emergence of clinical practice concerns the transformations of medicine which, under the influence of science, increasingly excludes the demand for treatment. The shift from the focus on listening to symptoms to the certainty of the pathogenesis through the observation of tissues, orients medicine towards the investigation of the sickness rather than towards the sick person. In a nutshell, the demand for meaning entailed in the experience of suffering is reduced to a request for health treatments. *The right to health becomes, due to medicalization, a sanitising of life***.** The issue is already well known and I do not need to continue. What I wish to underline is however the psychologists' lack of preparation when they found themselves dealing with the medical context and the culture pervading the second half of the 1900s; this culture gave an unexpected character to the reform itself and swept psychology away, sanitising it. And also on this well known point I will say no more.

The principle of equality of citizens sanctions the *universality and equality* of access to health services and to the treatments provided. First of all, we can see that alongside the protection of socially disadvantaged citizens in the cultural context just described, this principle reinforces the issues explained above and relates to the processes of sanitisation. It is more interesting to notice that this principle of equality is expressed, in the reform, in an organisational proposal of great importance: the development of the *decentralisation of the health services.* Under the pressure of the ideologies of that time, this principle took the form of an egalitarianism that used decentralisation as its banner. Rapidly and we might add, incompetently, geographical proximity filled the need for equality, and in the end it had to make do with decentralisation being reduced to a *client base*.
Apart from the legislator's intentions, there was the difficulty of translating decentralisation into a competence that could interpret the cultural and socio-economic diversity of our country, and find criteria to interpret the social demand expressed through the request for services. This complexity and the relative lack of skills in this operation of identifying criteria, meant that the "high" prospect of decentralisation to a certain degree failed to materialise. No competence was developed to the point of being able to produce a widely usable interpretation of the local areas. The proof of this failure is the insufficient production of written works of a broad scope to bear witness to the long hard work done in the health services.
At the same time, this decentralisation, acritically accepted as a sign of democracy in the health field, conveyed the offer of health services *alternative* to centralised hospital care. Moreover, the controlling body of the then Local Health Units, although ideologically surrendering to organisational incompetence, for a long time remained one of the first experiences of the Central State's decentralisation not only of health matters but also of administrative services. What was certainly done in that period was the construction of new models of living together between health services and social services, in the sense of proximity to problems and above all of support for social development.

Decentralisation has also been the organisational model that has given the greatest opportunity to different professional cultures to engage in dialog and also to clash in dealing with the social demand. This has happened not only in the sector of mental health, which immediately adopted the organisational form of the Department centered on the local area instead of on the hospital, but also in Family planning, in Drug addiction services (Law 685 dating to 1975 moved drug addiction from the field of crime to that of health, viewing it as an illness), in Disabled services, and in Occupational health services. While the structure of the health system was being decentralised, at

the same time the State's administrative decentralisation led to the establishment of psychosocial services in the municipalities, in large cities, in communication with the health services. There is no space to make an in depth examination of how these situations developed. I mention them to bring to mind the tightly-woven network of local area organisations that, thanks to the reform, brought in through the health system a period of proximity to the local cultures in our country; and to underline that all these organisations saw the introduction of numerous psychologists whose professional influence has not been sufficiently studied both in relation to the growth of the structures themselves, and in relation to the contribution they made to elaborating a theory of social processes undergoing tumultuous change concerning the family, youth culture, social exclusion and work in Italy.
I will examine only the transformations that *the family* has had to face**,** to show the crucial points of cultural transformation on which the local health services intervened (family planning, school and disabled services) and about which I hypothesise a role in producing psychologists' identity.
Let us use Pietro Stampa's Chronology[1] and supplement it: in 1975, parliament passed the new family law (law 151) and a few months later the law setting up the family planning centers (law 405). The limited initial funding allocated for their creation was greatly increased in 1978 (law 194) to ensure that the law on voluntary abortion could be put into effect. Following the path I am proposing, I want to look at a gradual detachment from the "naturality" of the concept of the family in those years and at the "de-biologization" of family ties. Much more thoroughly than in the court-rooms, the locally based health services, and in them the psychologists far more than the gynecologists or the pediatricians, who were protected in their technical roles, translated the social mandate that was implicit in laws entailing a dramatic cultural innovation, into interventions on adoptions, birth control and marital counselling.

Let us look at this in more detail.
The law on special adoption, promulgated in 1968, embodied the principle that adoption, in relation to inheritance, protects the affective and financial needs of the adoptee and not the financial needs of the adopter. This is the complete cultural reverse to the pre-eminence of paternal rights and needs, namely of the person leaving an inheritance, that had been the basis of family law up to that moment. What's more, by means of the referendum on divorce (1974) and the new family law (1975), the parity of spouses and of their responsibility towards the children was established. Which children? Legitimate, natural, adopted. What I wish to stress is the debate of that time between the supporters of the natural family and those of the family as a community of affects, with eventually a clear convergence of law on the latter conception, which leads the family to be conceived of as detached from its so-called *original naturality*. What are the two principles that in converging triggered this transformation of the family?
First of all, the principle of *equality in family relations*, traditionally based on a hierarchical difference or at any rate a disparity tolerated or even confirmed by the law, for instance with the question of adultery. This lead to a change in the position in the family of the woman and children, with a consequent change in the traditional paternal position. I would like to point out that alongside the propositions introducing new principles, the law cannot but leave some gaps, which produce resounding effects: while the equality of the children and therefore the legitimation of the importance of their position is affirmed, there is no new proposition on the position that emerges as the one most dramatically transformed, namely that of the father and husband. The staff who implement the activities of family planning centers, many of whom are psychologists, encounter in these facilities a demand that includes the need to follow and share this profound process of change, which unsurprisingly is still going on: just this year for instance we saw the successful launch of a book on the paternal role[2].
The second principle brings us more forcefully into the health field: family law ends up introducing and encouraging the progressive *rethinking of the importance of the biological fact* or the blood tie,

[1] Cfr in the same issue of the Rivista the article by Pietro Stampa: Chronology 1970-2000.
[2] Recalcati, M. (2011). *Cosa resta del padre? La paternità nell'epoca ipermoderna* [What remains of the father? The paternity in the hypermodern era] Milano: Raffaello Cortina.

as it used to be called, as the foundation of family relations. This rethinking gradually takes a clearer shape with the laws on special adoption, the recognition of children born out of wedlock, up to today's well-known debates on assisted conception. There is a continuity of the discourse designed to reduce the importance of the biological aspect.
Let me read Amedeo Santosuosso (1996), judge and bioethicist:

> […] the pathways of affirming equality and de-biologising family ties are so interwoven, and strengthen each other so much that it is the so-called natural family, technologically extended in the possibilities of reproduction, that seeks in the adoptive family a criterion of ordering relations, so some statements take adoption as the reference model (p. 127).

I wish to underline an important washback effect of these cultural transformations of the traditions foundations of the family, naturality and the biological tie (we have referred to the juridical discourse valorising the function of declaration but also interpretation and anticipation that laws have for changes in mentality): law 194/78 legalising abortion reinforces the *individual right to judge one's own health*, the right that justifies the demand for a voluntary abortion. The very definition of health emerges changed. How is health defined? It is health in the sense of health that cannot be justified in any other way since it is defined by the individual. The endangering of one's health is the reason, in the case of law 194, that a woman decides to have an abortion. It is not a matter of a more specific health, physical or mental, that can be diagnosed as the presence or absence of illness, but of health as the very perception for the individual who is talking about it. Exerting this right to define one's health when faced with abortion, needs to be done in the health facility: in family planning centers the doctor, often working with the psychologist, is called on to make an evaluation, not a diagnosis, to witness/attest to this subjective declaration.
After a decade of intense activity in the local areas, family planning centers entered a stage of irreversible decline. The problems linked to the life of the couple (what is the couple today?!), to so-called natural/artificial procreation (?!), and to adoptions, have not disappeared: where can they find a place where they are recognised and interpreted? In the ultra technological centers for "infertility"? In family medicine? In Mental Health Centers? In the rooms of psychotherapists? And what role has the psychology profession played in these facilities which in 30 years have already run their course? What effect has this stage left in the psychological identity?

Let us go back to deal with this question from the viewpoint of the transformations in mental health. Meanwhile remember that laws *180 and 194 were passed in May 1978* while the State was under seige during the Moro kidnapping. The fact that these events were going on at the same time suggests an acceleration, if not an actual coup, in promulgating these laws which were to leave their imprint on the foundations of the Italian health system, in the form of the 833 passed at the end of the year. Renzo Carli often reminds us that Basglian-style psychiatry reached the peak of its power with the 180 which immediately seemed to be a hasty, extreme legislative intervention: extreme in its symbolic significance, the symbolic reversing of the figure of the madman from dangerous persecutor to victim of institutionalised persecution, more than in its practical consequences (as you will see in Turin, the Racconigi Psychiatric Hospital closure was only completed in 1988 and that of Rome's Santa Maria della Pietà Hospital in 2001).
I will now underline a generally neglected aspect of law 180 which is however in my opinion of great relevance in the transformation of the health culture and of health in that period.
Above I recalled the individual's right to judge his own health, highlighted in the 194. Correspondingly, and in reinforcement of this right, the 180 "is the affirmation of the right to health as a *negative right*" (Santosuosso, op. cit., p. 134). What does this mean? It is the right to not receive undesired care unless… And the three articles of the 180 describe this "unless", legitimating a Compulsory Treatment Order. Law 180 and later the 833 do not legislate on the positive right to use the Health Services, so it was not until the first National Objective Project (Progetto Obiettivo Nazionale) that we could see an illustration of the aims of the Mental Health Services set up 10 years earlier. As Renzo Carli again reminds us, in the 180 there is no premise grounding for instance the provision of psychotherapy, which makes it even more interesting to interpret the spread of this provision in the newly established Health Services. Instead, in the law there is the space left empty by a negative right from which to derive "positive provisions". Deriving

from a negative right, the new provision of services brings with it a symbolic trace of lack of limits, and lack of context. Emotionally, I would say it has an effect as if protection were lacking, like a train hurtling along a track with no signals, and no stations (as in the song of the time "La locomotiva" by Guccini). I cannot refrain from mentioning in this regard an important "anthropological" feature of the creation of the local area services and of Mental Health in particular, that is, the young average age of those who were present at their birth, and instrumental in opening them and getting them to work.
Let us get back to the transformation of the concept of health outlined earlier (what we called the individual right to judge one's own health) to understand how this, reinforced by the right "not to receive undesired treatment unless..", established by the 180, influenced the *doctor-patient* relationship and more generally, the citizen-health relationship, i.e. the public health system as a whole, in the sense that the relationship of health constantly swinging between individual rights and common good, was unbalanced in favor of the former. In the field of mental health we witness the development of two transformation processes that were not obviously convergent: while the 180 promoted a stronger anchorage to medicine by taking psychiatry away from the control of the provincial authorities and police and by making admission to general hospitals compulsory, it reinforced the role of individual decision-making in the person's health. And what is this decision making if not a psychic act? The decision-making power of the person involved in health practices is the main channel of transformation designed to valorise the aspects of health we call "psychic". From within the technical logic that pervades medicine, the psychic takes the shape of an object of technical intervention for the individual, at the service of his judgment and therefore of his request. We therefore see the legitimation of a declaration of psychic distress even when one cannot talk about mental illness in a psychopathological way. But we will examine this elsewhere. I wish to underline that these legislative interventions and the strengthening of the "individual" rights that they convey, throws the door of health, and especially of mental health, open to psychologists. I hope that through the legislative references I have made, and through the affirmation of principles representing a strong cultural break and which underlie the establishment of decentralised services, one can understand the social mandate behind the large scale inclusion of the psychology profession in the health system. However, we would not be able to understand the tribulation, and also some aspects of failure, unless we kept in mind the legislative and organisational premises of this "psychologisation" of the health services.

In his Chronology, Pietro Stampa has wisely included *Law 285 of 1977* promulgated in order to develop the role of the cooperatives and designed to increase youth employment in the cultural and social field. It was not only Health in the recently established decentralised services, but also the Town council areas (think of the opening of local libraries in Rome) that used this law to implement programs of development of health services and of culture. In fact, many of these cooperatives were hastily set up *ad hoc* to guarantee their members entry to the newly established services, which were already suffering from the freeze on hiring via public examinations. In the span of a few years the members of the cooperatives formed under the 285, became employees of the facilities they had entered as cooperators, through an amnesty. Very often, the health services, thanks to the 285, used the young psychologists just graduated from the new faculties. For instance, in the whole of Lazio, starting from 1979, various cooperatives provided the then Mental Hygiene Centers with "animators", needed to carry out the re-socialisation of patients released from psychiatric hospitals.
Therefore many psychologists entered cooperatives as animators, but only in a virtual sense, just long enough for them to be handed over to the health services: in this twofold stage they had no experience of belonging to a social cooperative facility and after losing their recognition as psychologists, they found themselves having to deal "as animators" with the complex problem of reintroducing mentally ill people into society. That is not all. Being scattered throughout a great number of fledgling facilities, without a strong connection to the psychologists' professional identity, encouraged the psychologists in search of professional tools, to find anchorage in psychotherapy. Alongside the systematic psychoanalytical, or more rarely cognitivist-oriented, identities acquired outside the services, far removed from the issues that they encountered there, the animator/psychologists researched and participated with the other staff of doctors, nurses and social workers, in developing the new identities of health service staff. It was often a matter not of a

health service identity, but of idiosyncratic local characterisations, put together by personalities endowed with experience or also competence or charisma (some senior psychologists, some psychiatrists). It is impossible not to notice the violence on the young community of professional psychologists introduced by the recruitment operation I have just described: an operation that a whole generation of psychologists has felt to be its "*original sin*", and this can be seen in the current efforts to get rid it. It is the unwitting sin of being uprooted from psychology, from their only strongly identifying competence, to pass on to psychotherapy, and even more distressing, the sin of having, in the name of therapy like the doctors, stopped taking responsibility for interpreting the complex mandate given to the local area services as well as for the analysis of the social demand presented to the services.

The animator-psychologists of the early years under the 180 largely owe their entry into the health service to the broad project of *deinstitutionalisation.* It is very interesting to see the work on Basaglia by a group of students from the School of Specialisation. It should be remembered that the process of deinstitutionalisation did not just concern the area of mental health. The Basaglian imprint is on all the health services: think of the family planning centers as regards the exclusion of women, think of mother-child services for orphans and the disabled. All the anti-institutional movements bear a Basaglian imprint. We know however that Basaglia did not have a very favorable attitude towards the presence of psychologists, in fact he was known to be wary of psychology, and in favor of the Anglosaxon sociological line on mental illnesses. Once the falsity of the neutrality of the techniques was revealed, his *staff-member* could never be defined by a professional competence. In particular I wish to underline that the fight against institutionalisation brought with it a distrust of organisational knowledge, which was considered a compromise with the technical logic resisting change. This led to neglect and disinterest in the organisation of the health services whose internal functioning was for many years guided by values and ideologies of which we have experienced both the transformational power and the effects of ignoring reality.

While in other countries the clash between the medical/health logic and the economic/administrative logic occupied the field of transformation of health organisations, in our country the clash, in the years preceding the reform, focused on the incompetent confrontation between a medical/technical logic and a political logic. When the business-style process of the reform was completed the population of "managers" were found to be incapable of interpreting the demands made: on the one hand the doctors, mainly entrenched in a logic of individual responsibility of medical action, and on the other, especially in the local area services, the psychologists, who saw the negation of the organisational role typical of the logic of treating the individual, as well as the profession's lack of juridical/administrative culture, which was perhaps not worrying to the profession itself due to the long absence of a professional Order.

Conclusion

What has the public health system asked of psychologists? Using this question to seek the roots and the pressures of psychologists' professional identity made us turn to the identification of aspects of the social mandate entrusted to the National Health Service (Servizio Sanitario Nazionale) which, far more than the health project, have contributed to the construction of "Italian-ness". The young psychological identity finds a major anchorage in the public health system, even when there is no direct membership of what many feel is one of our country's solid and valorised "institutions". I like to think that psychologists are interested in participating in its governance.

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