Clinical psychology today, between theory and practice, training and research: a brief contribution to an open debate[1]

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In this article we would like to propose some points contributing to a reflection on the fundamental characteristics of Clinical Psychology and to participate in the debate, never resolved, on the essential dimensions of the training necessary for its practice.
The boundaries which define the framework of our discussion on certain aspects of the fundamentals of Clinical Psychology can be synthesized by the following points:

- The key reference to the importance of personal experience and subjectivity in clinical practice, on both the part of the patient and the part of the psychologist; the related concepts of specificity, recognition and encounter of specificities;
- The undeniable importance of the clinician's person, and the real relational matrix peculiar both of the evaluation situation and treatment;
- The developmental perspective which animates clinical comprehension and subsequent intervention (comprehension which understands patients starting from their history and which aims to favour their development, without reducing the treatment to a mere "cancellation of symptoms");
- A perspective on psychopathology which is not reduced to behavioural and symptomatic manifestations (though implying them), and which regards the essential themes of personal existence and the impossibility, for the individual, of constructing self-accomplishment in interpersonal relationships and in the different domains of his/her personal development, each of them with its own specific aims and needs; -
- A conception of aetiology which keeps account of the context of the attachment relationships in the patient's developmental background.

Clinical Psychology: a brief reflection on its foundations

Many are the definitions proposed for this discipline. We wish to remind, as an important reference, the one given by the College of Professors and Research Assistants of Clinical Psychology of the Italian Universities.[3]
Thinking in terms of Clinical Psychology, first of all, implies to deal with *suffering* and *pathology*.
As we know, pain and psychopathology do not have a linear relation with one another. Severe psychopathologies are not experienced with a subjective

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[3] Cfr.: http://www.collegiopsiclinicauniv.it/ita_ambiti.htm.

awareness of intense suffering; in some situations, suffering can be “migrated” and express itself in the body or even through people of the individual relational context.
The better mental processes work the more individual will be able to master pain connected to heavy troubling and unbalancing events of his/her existence by the search of meaning making. Let’s think about, for example, our necessary life losses and how these can be elaborated only through a process of mourning which implies a deep pain. In severe psychopathologies, instead, the inner experience of pain is altered exactly because of the fragmentation of subjectivity: where the suffering could be, it is erased by pathology. If psychopathology overwhelms, it will also structure itself by giving life to a large variety of symptoms (which, as we have said, can also show themselves through the intimate people of the context, given the essential relationality of mental functioning).
As far as symptoms are concerned, the progresses of clinical field has allowed us to describe them better and to fit them with great precision into more and more evolved and refined nosographies. Development in nosography has shown its usefulness above all in offering diagnostic categories which have allowed experimentation and the availability of more and more effective psychotropic drugs, which allow a certain control and, at least, a partial remission of the symptoms; nevertheless, to take this approach to extremes does not take into account the integrity and complexity of the person in the context of his/her significant relationships. The development of Clinical Psychology allows us to understand, more and more clearly that a symptoms and nosography centered attention risks, paradoxically, to perpetuate, in the relationship with the patient, the cancellation of his/her subjectivity strictly tied to the nature of his/her psychopathology.
On the other hand, especially when Clinical Psychology addresses itself to what is specific to it, that is subjectivity and relationships, it would offer the possibility of understanding and intervening in a broader and deeper way on psychopathology. The discourse about suffering and psychopathology can not neglect to make reference to subjectivity and relationships, considered as where personal experience meaning making takes place.
During the history of psychology there have been attempts to exclude *subjectivity* and *meaning* from their own fields of study and intervention (e.g., think about the first Behaviourism and the starting Systemic-relational approach). Today the theoretical trends which constitute the different “souls” of Clinical Psychology seem to be less in conflict with one another; instead, a conflict is now existing as regards the psychobiological wave which is trying to sweep away every reference to any dimensions which are not material or objective.
As clinical psychologists, we must seriously reflect on these reductionist positions: they do not belong only to the past and, maybe, do not concern only “other people”. We are arguing that our mind struggles “structurally” to bear complexity, above all when it finds itself enmeshed in hard suffering situations; the need to defend oneself through simplification and reductionism is a risk which every one of us runs in being involved, as person and as professional, in clinical practice. Nevertheless, we could not allow this need of defence is turned on its head and it is ideologized by strong viewpoints (epistemological, theoretical, pragmatic and political) which would have been more suitable, perhaps, in the scientific context of two centuries ago.

In other fields of clinical practice, the material dimension of the body and the (presumed) objectivity of the symptoms (somatic or behavioural) may preserve a sense of safety, both in emotive terms and of professional identity; but, from the Clinical Psychology standpoint, this sense of safety transforms itself in a security defensively gained which risks losing what is essential to it. In this case, what is essential is invisible to the eye for those who don't want to see it.

Even the concept of *mind* may be defined (and it has been) in many ways. At a low level of theoretical abstraction, and within the conceptual context here outlined, we can consider *mind* as a kind of complex apparatus (a system of processes) in pursuit of the meaning of experiences. We are not able to live without meaningfulness or without the sense of being significant for somebody (we consider significant other too). Today, there is a convergence, between several psychological perspectives, in underlying the relational construction of personal experience meaning, and subjectivity is conceptualized as in an ongoing and mutual dialogue with inter-subjectivity. Therefore, we need significant *relationships* to make meanings more consistent, shared, convalidated, inter-subjectively recognized.

In any case, if subjectivity is where the construction of the meaning of experience is accomplished, it cannot be said to be a given, but it needs to be developed. As we pointed out before, in fact, the most severe psychopathologies show how subjectivity can be fragmented, discontinuous, "swept away" just in some of its peculiar dimensions or levels. Mind is a broader concept which also includes processes which attest and implement the failure in finding a meaning. That is to say, these processes bear witness to the failures which have characterized personal *development* in a traumatic way.

The way of intersubjectively constructing the meanings of experience develops through the history of relationships. As the researchers tell us, the first relationships are essential above all in regulating affective states. If the infant experiences the possibility of regulating his/her own states and, also, his/her caregivers' states, both in an autonomous and interactive way, within a variety of relational exchanges characterized by organization and flexibility, he/she will have the possibility to base his/her sense of vitality (which is precisely the developmental foundation of his/her sense of having a functioning mind) and a whole, consistent, integrated with the relational context of significant other, subjectivity.

Human beings, in fact, may develop a healthy and functioning mind only if, right from the beginning of their life, they are significant to their attachment figures.

The relational context of human development sets up the matrix of meaning making in following relationships and of their significant triggers.

As a result, referring to the *developmental dimension* is another mainstay of Clinical Psychology. The failure of the developmental processes, as we briefly outlined above, involves the onset of psychopathology: this entails the founding dimensions of mental life upset, that is the breakdown of subjectivity and relationships as sources of meaning.

Psychological clinical intervention could be thought of, and set in, this framework. Subjectivity and relationality become both *objects* and *instruments* of Clinical Psychology: objects of observation for the comprehension of psychopathology, objects of scientific study; instruments of intervention and way for change.

Before taking into consideration some points related to Clinical Psychology practice and training, we would like to underline the importance of scientific research.

Role of theory and relevance of research in Clinical psychology

Clinical Psychology, as a scientific discipline, must be devoted to the growth of knowledge about its own specific topics, as the ones introduced before.
A characteristic of scientific disciplines is the development of models and theories through the expression, application and improvements of a *method* which allows, as better as possible, the comprehension of the objects of study. Scientific method drives to look for, and to offer, continuous guarantees for a knowledge formulated by a discipline, in terms of orderliness, availability, disciplined use of reason, and referring to empirical data as a check for the theoretical hypotheses.
Considering Clinical Psychology as a scientific discipline offers many advantages, but research is a practical activity with its own needs and peculiarities; since our discipline is a professional practice too, the framework scientific foundation of its knowledge can be exploited within, is a very complex one, and it must be respected in its complexity.
The passage from the context of scientific research to Clinical Psychology practice one is not taken for granted, and it is constantly troublesome, given the fundamental relevance assigned to subjectivity and relationality (as well as to other objects of study as suffering, relationship, early development etc., which are difficult to investigate experimentally) by clinicians. The connection between clinical practice and research is consequently in an ongoing construction.
First of all, in our field, research is *conceptual and theoretical.* The systematic and argued clarification about the notions used for theoretical formulations is a crucial passage for the growth of knowledge even in Clinical Psychology.
Well formulated theories offer the possibility of gaining experience of more articulated observations. Theories work by constraining the observer's look at specific levels of reality that these same theories help him to focalize. Therefore, theory offers *constraints* and *possibilities* as indissoluble conditions for scientifically-orientated observation.
Even in clinical observation, theories allow the psychologist to take the specific point of view from which to analyse some of the many facets which make up the complex psychic and relational reality of the patient (as individuals, couples or families). Nevertheless, the clinician should not be a "neutral" and "detached" observer referring to his/her object of study: on the contrary, he/she must be able to involve himself/herself, to empathize with the patient, to widen his/her observation through his/her whole experience and feeling, with his/her ideational associations and fantasies. This is necessary to observe subjectivity and relationality, the specific objects of Clinical Psychology.
Theoretical knowledge is also necessary to be able to observe clinical phenomena in a way which can be shared by the scientific community: it is necessary but not sufficient. One thing is the sharing of knowledge between colleagues, another is its *co-liveability* among themselves and their patients.
Theoretical knowledge and personal training are inextricably interwoven aspects. In order to be useful, scientific research in Clinical Psychology must

develop models which take this complexity into account and help to articulate theoretical knowledge and subjective involvement in harmonious ways, peculiar to each clinical psychologist.
Besides the theoretical dimension, others are to be considered.
As we know, Psychology as Science of Man has been created by great authors who suggested wide thinking on nature and functions of mind and Clinical Psychology has been developed above all by clinicians who were able to enrich theory thanks to their reflections on their professional experience. *Historical research* on the thoughts of great authors is therefore a constituent and essential part of our discipline.
Another central dimension to the development of scientific knowledge in Clinical Psychology is *empirical research*. Even if it has not been as representative as for the history of its different orientations, empirical research has now significantly increased, both quantitatively and qualitatively, and it is offering relevant contributions in many fields pertinent to Clinical Psychology: psychopathology, diagnostic situation and its instruments, psychotherapeutic process and outcome, clinical interview, counselling, brief and focused interventions, couple and family relational dynamics, mother-infant relationship during the first mental operations formation, life-span development, functioning of the brain and its relation with experiences and psychic functions, etc.

Practice in Clinical Psychology and change.

As we said, clinical psychologists are not, for the most part, theorists or researchers in their discipline. Clinical Psychology is, also and above all, a practice, a professional practice, that's so, clinical. Then, let's address our attention from the discipline to its protagonist: the clinical psychologist.
In fact, a premise of clinical work is that patient meets psychologist as *person* and starts a clinical work with him/her. Therefore, individual differences and subjectivity are not the problem, but the essential ingredient in the practice of Clinical Psychology. Clinical psychologist is guided by a shared theory and relies on a training developed within a specific perspective, but his/her intervention will be effective only if it is personal and creative, thus unique, singular and addressed to the specificity and unrepeatability of each patient and of his/her situation.
Before we underlined some of the general characteristics of Clinical Psychology at the level of its foundations and overlaps from a theoretical point of view; now we are moving to the field of intervention and practice and we must emphasize differences and specificities which assume a central importance and role: differences among psychologists and differences among clinical attitudes supported by different theories, nevertheless close and similar in their epistemological premises and their critical assumptions about mind and psychopathology, and about the relevance assigned to subjectivity and relationality.
During its more than hundred year history, several paradigms of Clinical Psychology have assigned a different role and importance to cognitive, emotional, behavioural and relational factors in therapeutic process. Moreover, these factors, or dimensions, have not always been conceived in the same way; the translation of different concepts articulated by different theoretical orientations, even if supported by the shareable and crucial objective of

integration, always involves the risk of flattening out and betraying the complexity of each theory and of its specific conceptualizations.
In any case, we can try, as well on the side of clinical practice, to identify some of the fundamental dimensions which characterize psychologist's work we can agree upon, even though our belonging to different orientations.
Being concerned with problems, suffering, psychopathology, clinical psychologists get involved in order to promote change. Their intervention, moving from the request of those who ask for help, is not merely aimed at understanding, not merely cognitive. In a clinical context, patients' requests are always implicitly requests for growth, for the fulfillment of coerced potentialities (for "health" in its broadest sense). Even the understanding moment, or better the cognitive dimension (as it persists as long as the intervention lasts), does not refer to the construction of objective knowledge but to the construction of subjective and relational knowledge, that's to say a kind of knowledge orientated to the search for meanings and meaningfulness.
In effect, we could say that in a clinical domain, a characteristic of psychological intervention (in any context we wish to imagine it and with any problem or pathology) concerns the activation of research processes aimed at searching for meanings and meaningfulness. Patients need to find again – or to find – the sense of their own mental functioning as something trustworthy and endowed with an interpersonal value.
The enlargement of patients' knowledge of theirselves, the functioning of their interpersonal relationships, or their past, is an important aspect of intervention, but it is not sufficient. The relevance assigned to the construction of new narrations too, as organizational corner-stones of subjective knowledge of interpersonal area, is to be understood according to this viewpoint, that's to say, in the intersubjective co-construction of the sense of freedom of creating new points of view, through which patients may experience their significant history dialogically re-told.

The problems of training in Clinical Psychology

Which competences are – in brief – necessary to a clinical psychologist?

- We believe they concern some basic dimensions which are synthetically outlined in the list below:
- Theoretical and methodological knowledge, scientifically founded, and competence of making them co-liveable with himself/herself and with patient, besides being intersubjectively shareable by the community;
- Personal training and self-knowledge;
- Observant, deductive (aimed at recognition both of concepts and categories) and intuitive competences, aptitude in clinical listening and empathizing;
- Interpersonal competences, both personal (empathic and pragmatic) and connected to the professional role assumed in relationship with patient; ability to understand interpersonal processes linked to the construction of intersubjective meanings and the possible distortions of these processes;
- Being able to employ the relationship with patients in order to activate – in new ways – the processes of meaning making of their experiences;
- Competence in making significant patients' experience;

- Ability in communicating thoughts that are to be messaged to patients in a simple way.

How are these competences reached?
The issue about training of the necessary competences to Clinical Psychology practice is now extremely ticklish and urgent. In the debate on this controversial theme, some contributions appear to be necessary: those coming from University (an institution specifically appointed to education) and, above all, those coming from University Psychology (an actor intrinsically protagonist in this debate, that paradoxally, some people would like to set in the role of observer).
Which is the actuality of training in Clinical Psychology? And which contribution can the Faculties of Psychology offer to it?
The new Italian University system, with its explicit aim of reducing professional training costs, have favoured an increase in enrolling and a reduction in dropouts and degree completion time but, closely because they allow students to complete their course of study in a shorter time, they imply at the same time, as observed in the most Athenaeum in our country, the institutionalization of a "brief teaching of minimal knowledge" in the academic path and a consequent excessive apportioning of courses.
Though, learning and knowledge processes are not necessarily predetermined and linear but, rather, always various and subjective. Repetition and redundancy may be sources of richness and guarantee of depth and solidity in comprehension: according to this position, the idea of "minimal knowledge" is reductive in itself, at least because it erases the absolute "need for time" necessary for promoting an authentic learning. Clinical training, in fact, needs to re-qualify "slowness" in developmental dialogue and the possibility of metabolizing and therefore internalized the Thought Models.
Training in Clinical Psychology is, par excellence, an experience of strong personalization: the knowledge it promotes is therefore not reachable in a mechanic and predetermined way, as it necessary implies a gradual process of internalization. A good didactic activity consists in the aptitude of dialogically triggering and continuously stimulating training dynamics of this kind.
On the contrary, the normative confusion and the chaotic debate, now actual, risk to neglect the peculiar function of didactics in the specific Clinical Psychology field, and its chief function in the diffusion of that kind of knowledge simultaneously transmitting both concepts as "growth", "maturing", "individualization" and that ones related to subjectivity and relationality.
Consequently, today more than ever, we must look at a culture of ideas and of creativity.
The new Italian University system has many faults which penalize training in Clinical Psychology. For example, fragmentation of courses implies a lack of exams favouring *mental synthesis*, accessible only after having been long immersed in studying a discipline, grasping the language and the categories which characterize it, but not only for some months. From the instructor's point of view, maybe fragmentation of courses allows transmission of contents, but makes extremely difficult, perhaps impossible, meta-communicating the essence of a discipline to students. To a thoughtful listener, students communicate a sense of disorientation faced with the difficulty in integrating the contents learnt in different courses, quickly chewed up and not metabolized till making them theirs own.

To this, the mentality of numerically crediting every single minute of classes and/or every single page studied is to be added. But, how can the work necessary to comprehend the nature of time and space reality in clinical training be computed, according to unit of measure based on credits?
On the other hand, the new Italian system has had the merit of forcing a reflection on the need for specific curriculum already in the courses which precede the Second Cycle Degree. Those who graduate in the Second Cycle of Clinical Psychology have had the opportunity – differently from other students who graduate in other disciplines, such as, for example, medical ones – to face a great deal of contents which are intrinsic and specific to the discipline. As an example: knowing a perspective on psychopathology such as the one outlined above, or getting an idea of treatment not as elision of symptoms but as taking care for a person. Briefly, getting an idea of treatment as something electively aimed at knowledge and valorization of the individual's subjectivity, meaningfulness and growth; a kind of care obviously mediated by the necessary personal involvement of the clinician.
Endowed with this knowledge, graduates in Psychology can have access to post-degree training, necessary and fundamental for deep attainments in clinical work. Many reputable and equipped schools of psychotherapy are actually available and – at now – only two academic Clinical Psychology Specializations (post-graduate schools) in the ambit of Faculty of Psychology, have survived. These latter will be compelled to conform to a new legislation, born out of various necessities, but not always carrying values compatible to the construction of competence corresponding to the ones outlined above.
Next future we will must strongly engage in favouring further opportunities of training and expression if we really want to create a class of professionals who possess, at least potentially, an even more important role in disclosing new horizons of meaning for people in anguish and pain who turn to them, and so in contributing in various ways to the growth of society itself and of our culture.