

Expectations and assessments of psychotherapy from the point of view of psychotherapists and clients

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Introduction.

The research we will present set out to study the expectations and assessments of psychotherapy expressed by a group of psychotherapists and a group of clients, proceeding with two parallel investigations, the data from which were then compared. This work seeks to contribute to psychotherapy research by exploring an area which is not often examined in such studies. We are referring to the experiences and the symbolic significance with which psychotherapists and clients represent the psychotherapy experience to themselves. As it ventures into largely unexplored country, the research takes the form of an initial survey of the themes in question. In terms of the model we will adopt to examine these experiences, we will talk about collusion, meaning the emotional dynamic by which people symbolise a context that they share¹. The experiences of the psychotherapists and patients are therefore considered not in their individual dimension, but in their capacity to express a 'demand culture' in psychotherapy, seen from the point of view of the expectations with which the patients turned to it, and of the service the psychotherapists think they are delivering in response to these expectations. This study thus sets out to contribute to the debate on the relation between the commissioner of the intervention and the social mandate for psychotherapy intervention, an issue of particular interest for those that deal with development in our profession.

Psychotherapy between social mandate and the commissioning figure.

Every profession enjoys a social mandate, or a process of legitimation and consensus that justifies its practice and vouches for it. This is quite a widely supported social representation, represented by laws and social bodies, which make sure a certain problem is associated with a specific professional competence. We are talking about the cultural and normative model that allows the provision of professional services to meet the demand.

According to many authors, among whom we wish to mention R. Carli (1997) in particular, in order to give itself social credibility and legitimacy, psychotherapy has relied on a professional world that already enjoyed a strong social mandate, i.e. the medical world. Psychotherapy borrowed terms like therapy and healing from medicine, a-critically in terms of aetiology, but with apparent success from the social legitimacy viewpoint. In actual fact it has little to do with medical therapy. This is where the problem arises. Doing psychotherapy with reference to the medical mandate means treating the demand of the person contacting the psychologist as a request for diagnosis and therapy, with the idea of being able to treat what the client proposes as if it were the expression of a psychopathological form to be linked to a classification in the corpus of psychopathology (Carli, Paniccia & Salvatore, 2004). One of the issues that derive from this is that the model of care in psychopathology is related to a supposedly normal or adjusted behavior. The literature dealing with research in psychotherapy abounds with references to psychotherapy models oriented to changing the

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¹ For more details on his models, see Carli & Paniccia (2003) and Carli & Paniccia (2005).

individual's behavior. This change coincides with the adjustment to the social norm (Grasso, 2006; Grasso & Stampa, 2006, Salvatore, 2006; Paniccia, Giovagnoli & Giuliano, 2008). While on the one hand the reference to care and healing seems to give psychotherapy social legitimacy, the individualist stereotype and the 'orthopaedic' aim related to it, in our view constitute the main limitation to the development of the psychology profession.

If the medical model is not automatically adopted as a matter of course, it becomes clear that those who go to the psychologist have problems, not disorders. Problems of relating with the contexts of living with others: family, fellow-workers, friends. Other disciplines seem to realise this. An example is philosophical counselling which is offered by professionals who practise it as an alternative to psychotherapy, which is seen as an intervention unable to deal with the demand of a person who does not represent himself as having a deficit or a maladjustment to be brought back into the norm. For Umberto Galimberti (2003), the person who asks for philosophical counselling, unlike the one that seeks psychotherapy, wants to benefit from his investment in life. There is no way of countering criticism of psychotherapy's capacity to respond to the clients' demand for growth. Psychology, especially the branch dealing with psychotherapy, is accused of being self-centered, closed in on itself, taking refuge in predefined criteria of normality and pathology, more interested in being accepted as a so-called exact science than in responding to its clients' needs (Achenbach, 2004; Lahav, 2004; Mace, 2001; Pollastri, 2005; Ranchetti, 2003, Sini, 1993).

In actual fact, the literature dealing with psychotherapy research seems determined to legitimise psychotherapy praxis in a social mandate comparable to that of medicine. For this reason, attention is focused on classifying and diagnosing disorders, with the idea that the interventions will derive from these diagnoses. If this approach is adopted, the expectations of those who go to the psychotherapist become of secondary importance and are not taken as an object of study. In more general terms, the client and his attitude to the therapeutic experience do not seem to be an analytical standpoint that is easy to manage. And yet in 1995 Seligman had already suggested, along with the classical efficacy studies, developing an effectiveness study, based on the systematic collection of data and on numerous patient populations with a treatment experience². Other authors have underlined how important it is to know the attitude of patients and their families when doing research into the effectiveness of psychotherapy. Among these, Strupp & Hadley (1979) and Karasu (1986) have argued that the ideal tool for assessing the effects of treatment should include the collection of patient opinions. As Coursey, Farrell, & Zahniser (1991) argue, even serious patients are able to express articulate opinions about their experience, if the research is based on an appropriate methodology. The research design proposed by Elliott (1999) moves in this direction. This author elaborates a post-treatment qualitative interview called Client Change Interview Protocol, designed to assess the possible causal link between the work carried out in therapy and the changes registered by the client. In the same direction we find the research of E. Fava (Fava, Pazzi, Arduini, Masserini, Lammoglia, Landra, et al, 1998; Fava, 2000), which, by using 5 questionnaires, studies patient opinions about the psychotherapy treatments received.

In the studies cited, on the other hand, the patient's words are not interpreted using psychological models. Above all, they are deprived of all symbolic relational meaning and

² Remember that efficacy studies measure the outcome of therapy under closely controlled conditions, as in a laboratory; *effectiveness studies* on the other hand measure the outcome of therapy under real everyday practical clinical conditions. Effectiveness studies emphasise "external" validity, that is, the generalisability of the results. As Seligman (1995) underlined, one of the main problems encountered by psychotherapy researchers is that of upholding both efficacy and effectiveness, since therapy that proves its efficacy in the laboratory but not in real clinical practice would be pointless.

treated as data to be taken literally. This data, with such a reading, can be compared and cross-checked with other data about the psychotherapist's or outside judges' assessment of the psychotherapeutic experience had. In this article we would like to propose a model for psychological interpretation based on Analysis of the Demand³ of the expectations of the people going to a psychotherapist, and compare them with those of psychotherapists themselves.

Methodology.

To study the collusive dynamics organising psychotherapy, we interviewed the actors involved in the intervention: psychotherapists and clients. Emotional Textual Analysis (AET) was carried out on the text of the interviews. For an in-depth knowledge of this research methodology, see R. Carli & R.M. Paniccia (2002). Here we intend to provide some basic information that may help to understand the reasons for the choice of this specific methodology in relation to the object of study of our research and to its aims. AET makes it possible to discover the affective symbolisations of a context, shared by those involved in this context. We call the set of affective symbolisations characterising a context and organising the relations within it the 'local culture'. The local culture of a specific contextual situation can be communicated and therefore known through texts produced by those in the situation. The hypothesis underlying AET is that the local culture can be found in the co-occurrence of some words, for which we use R. Carli and R.M. Paniccia's term 'dense words', in a specific unit of text analysed. Dense words are words characterised by maximum polysemy and minimum ambiguity. Polysemy refers to the power of evoking infinite emotional meanings that a word takes on when it is taken out of the specific language context in which it is found. The interpretative hypotheses for local culture are constructed by using clinical psychology models of social relations, with which the co-occurrence of dense words is interpreted. In constructing a hypothesis to interpret local culture we aim to identify the specific indicators of development of the context studied, starting from the potentialities expressed by collusive dynamics.

In the research we are presenting the context shared by the interviewees is the experience of a psychotherapy intervention. The texts analysed with AET were produced via self-recorded interviews with two groups of subjects: the first made up of psychotherapists, the second of patients stating that they have completed psychotherapy. The type of interviews conducted falls into the so-called free interview category, an interview that uses a stimulus question after which the interviewee is left to associate the key words in the question with anything that comes to mind. The role of the interviewer is to support the interviewee's association process, if necessary picking up the thread of the discourse without interrupting or guiding him/her.

The psychotherapists were asked the following *stimulus-question*: "In your experience as a psychotherapist, what problems are presented to you and what results do you think you will achieve?". The clients were asked: "For what problems did you go to a psychotherapist and what results do you think you achieved?".

Two AET were produced, one on the text of the interviews with the psychotherapists and one on the text of client interviews. For the statistical steps we used the computer program

³ The model of Analysis of the Demand was developed in numerous works over the years; for a summary of the proposal see Carli & Paniccia (2003) and Carli & Paniccia (2005). According to this model the problems that people, groups, and organisations bring to the psychologist originate in relations and it is in the relationship between the person presenting the demand and the psychologist that problems can be known and treated. The specificity of the clinical psychologist's methodology consists of thinking, with the client, of the emotions experienced in their relationship and using them to construct hypotheses for the development of the client.

Alceste⁴. We will simply show three stages of the analysis. In the first the researcher identifies the dense words from the whole vocabulary of the text. In the second clusters of dense words are produced, called 'Cultural Repertoires' (RC). In each cluster the dense words are ranked in decreasing order of χ^2 . The third identifies the factors that can explain the relation between RCs⁵.

Characteristics of the two groups interviewed, psychotherapists and clients.

The *psychotherapist* group was made up of 41 subjects. For the psychotherapists three variables were considered: sex, years of experience and work context, whether it was mainly public or private. As for the length of experience, at least five years were required. No allegiance to a particular school was required, since it was considered merely a seemingly definite, differentiating difference. However, this component was taken into account: ten psychotherapists known by the researchers were initially involved, divided according to orientation, and they were asked for further addresses of psychotherapists to involve. The tables below show the distribution of the psychotherapists' group for each of the three variables.

1. Years of experience	
5-10	10
11-20	16
21 or more	15
Total	41

2. Working context	
Public	20
Private	21
Total	41

3. Sex	
Males	13
Females	28
Total	41

The *client* group is made up of 43 subjects. The two variables considered for the clients were age and sex. The distribution of the client group for the two variables is shown in the following tables.

1. Age	
Under 30	23
Over 30	20
Total	43

2. Sex	
Males	16
Females	27

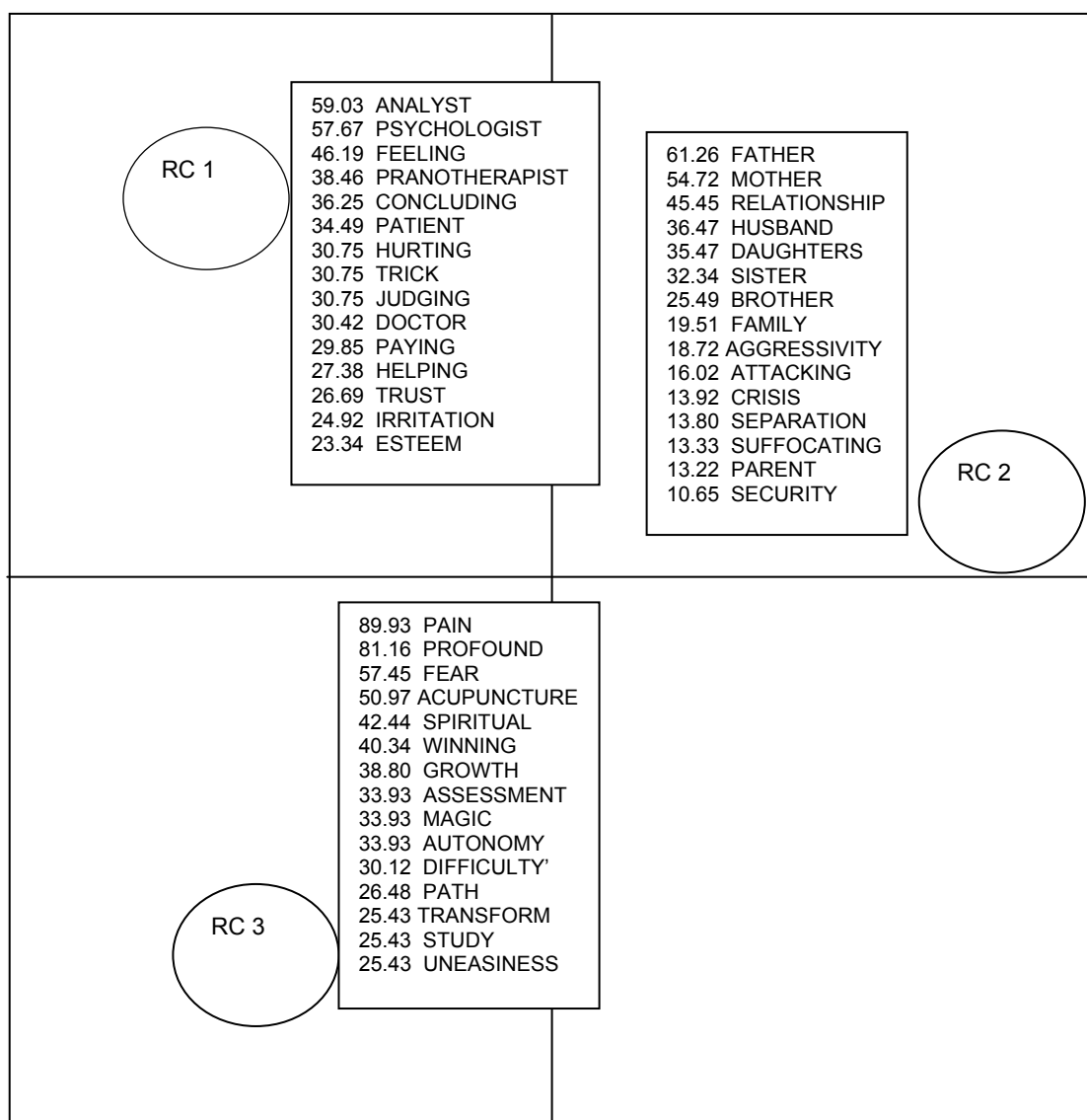
⁴ Analyse des L x mes Cooccurrents dans les Enonc s Simples d'un Texte, by Max Reinert.

⁵ Contributions to the research were made by Viviana Bonavita, Michela Nol , Federica Rastelli, Serena Tacconi, Valentina Terenzi.

Total	43
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The local culture of the client group

Let us now look at the results obtained from the two analyses. We shall start from the local culture of the client group. The analysis revealed three clusters, which in terms of the collusive dynamics model we adopted are called Cultural Repertoires (RC). The three clusters are shown in the following diagram on the factorial space. In each cluster the dense words are ranked by decreasing value of χ^2 .



Relation between RC and factors

RC	Factor 1	Factor 2
1	-.784	.816
2	.463	.030
3	-.660	-.971

On the first factor there is the contrast between RC 2, on the positive pole, and RC 1 and 3, on the negative pole. On the second factor there is the contrast between RC 1 on the positive pole RC 3 on the negative pole. We propose a reading of the local culture by analysing the three RCs that make it up.

Cultural Repertoire 1

The first meeting between dense words is between the *analyst* and the *psychologist*. The word analyst is used in the text as a synonym of psychologist and recalls the important place that psychoanalysis has in the representation of psychotherapy. The word, from the Greek *analýo*, I unravel, is related to a method of studying that breaks down a whole into single components so they can be examined and defined. The word psychology comes from the Greek *psiche*, soul, breath of life, and *logos*, discourse. The meeting between the first two words gives us the psychologist emotionally symbolised as an examiner, one who studies a deep, complex reality like a mathematical problem, as mysterious and important as the breath of life with which God gave life to men. The psychotherapist is associated to the psychoanalyst and the psychologist, rather than to the doctor or the psychiatrist. The doctor will only appear much later in the cluster. We are dealing with one who studies the mind itself, more than its pathologies. The first pair of words therefore focuses on one of the two actors of the psychotherapeutic couple, the psychotherapist, seen as one who studies the mind. The later instance of co-occurrence is found with the word *feeling*. The English term, commonly used in Italian, evokes a shared emotional experience, in the sympathy and understanding between people. Feeling evokes a bond, an emotional relationship where the confines of one and the other fade in the sharing. The difference between one who studies the mind, and the layman, can be attenuated or annulled by feeling. The next instance is *pranotherapy*. The word is made up of the Sanscrit *prana*, breath of life, and the Greek *therapeia*, I ensure, I heal. Pranotherapy is the practice of laying the hands on the sick person by the person who supposedly emanates a beneficial force. The person who studies the mind, with whom one shares a close bond, has the power to heal by transmitting a positive flow of energy. The first instances of dense words in the cluster bring together an expert and a layman, in a relationship that is made close by feeling, which annuls the distance. Later, the power of the scientist of the mind is placed at the total disposal of the person in need, with an illness. Science is joined to the healing power of the kings that healed people with scrofula by touching them with the royal ring and hand. The link between touching and healing is also present in our religious culture; think of Christ who healed by touching. If the therapist is the person who heals by touching, the other person, i.e. the patient, is the one who is touched. He is not required to do anything during the therapeutic process apart from supporting the representation of the therapist as a powerful healer king. From the opening words of the cluster it would seem that the primary problem faced by psychology is that of the relationship, here between an active psychotherapist endowed with authoritative power based on science, and a passive layman. This passivity is accentuated when the power of science merges with the power to heal through power itself: the healer king. The problem posed by the sharp asymmetry of power between psychotherapist and patient is solved by closeness and feeling, and by the fact that power is placed completely at the service of the one who is powerless. This representation of psychotherapy is totally centered on the therapist's power and on the asymmetrical relationship of the client with him/her. It is reflected in the importance placed in the interviews on power fantasies. Power is evoked in the psychotherapy relationship as the primary agent of being together. At the same time, power is evoked as a way of intervening to solve problems. This is not only power based on competence, but merged with it, there is power as such, i.e. power without competence. The client could be said to appear in this cluster as the one who suffers from his own lack of power, and who due to this, turns to psychotherapy. It is a client who thinks of power, whether it derives from science or is assumed as power in itself, as a form of intervention in his problems. The opening of the cluster is with a culture of power rather than of knowledge. The next instance is *concluding*, closing, locking, finishing, terminating. The

imaginary relationship is based on a problem-solving power; the solution leads rapidly to the conclusion of the relationship itself. The problem is solved and this brings the end of the relationship, which however has never begun if it seen as an emotional experience based on the knowledge of self and the other person. At the same time, a relationship featuring such violence and completely lacking in any exchange of knowledge has no prospects and must be concluded as quickly as possible. The following word is *patient*, thus introducing the other half of the therapeutic pair. Immediately afterwards comes *jar*, push against with force and violence. The concluded relationship is not actually finished; in fact, the other side of the closeness coin breaks in, and it is the difference that strikes, jars. Jarring signals a conflict, and evokes clash and irritation. The conclusion of the relationship and the solving of the problem have been totally illusory and only apparent. In fact the next word is *trick*, or make something seem different from what it is, especially in order to deceive someone. There is the awakening from the illusion of fusion, from the fantasy of a power devoted to you, and one is hit by disillusionment and the dawning of realisation. Then comes *judging*: moral judgement, but also the use of the faculty of wisdom, of realising. With the subsequent *paying*, it evokes a relationship organised by evaluations and payments. There is the psychotherapist's judgement on the patient, but also the patient's on the psychotherapist and that of both of them on the work that is done; the payment makes an exchange explicit and quantifies, limiting the value of how much is given to the client by the psychotherapist. Payment is in money, but it is also the cost of what is done, the awareness of the cost of one's actions. After the disappointment of fusionality and the experience of being tricked, reality emerges with its needs for judgement and payment, for recognition of the costs. Between judging and paying we find the *doctor*, who compared to the analyst, the psychologist and the pranotherapist, seems to offer a professional service that takes into greater account the real limits. Then come *help*, *trust*, *irritation* (unease, cramping), *esteem* (the act of appreciating). After the idealisation of a knowing, influential power followed by disappointment and the dawning of realisation, followed in turn by judgement and payment, or by an acknowledgement of limits, we reach a relationship featuring ambivalence and unease, but that also permits help along with trust and esteem. This first RC reveals a psychotherapeutic path identified with the development of the psychotherapist-patient relationship. The process starts, with the most central words in the cluster, from an idealisation of the power of the psychotherapist, identified with the controlling, resolving power one would like to have over one's own problems. This fantasy is later disappointed, to end up in an ambivalent relationship based on the acknowledgement of the limits of reality.

Cultural Repertoire 3

The first word, *pain*, ('dolore' in Italian, from the Latin dolere, dol-eo, I feel bad, I hurt) evokes suffering, evil, but also problems: "if I don't find work it'll be painful" ("se non trovo lavoro sono dolori!"). The first meeting is with the word *profound*. The term evokes something internal, obscure and intense. An affliction strikes someone, and is experienced as something internal, obscure and suffered in solitude. The word *fear* follows, the intense upheaval caused by something one wants to escape from, experienced as a danger. One feels an obscure internal suffering, like an enemy from which one wants to get away. Then comes a therapeutic practice that is part of alternative medicine, *acupuncture*. The acupuncturist intervenes to activate a vital energy which is supposedly blocked. The suffering body is penetrated by a thin sharp object. The suffering is confined to the body, the intervention is accurate, physical and hopefully final. One runs away fearfully from an intense obscure emotion that is seen as a danger, an emotion that blocks and immobilises. The enemy pain, other from the self, is confined to the body and entrusted to the acupuncturist. In the psychotherapy relationship foreshadowed in acupuncture the frightening emotions, reified in the suffering body, are eliminated with an accurate, final intervention, where neither words, and much less ideas, have a role. The next word is *spiritual*. Spiritual is what consists purely of spirit and not of matter, what is non-corporeal and immaterial. Spiritual is what concerns the inner sphere, as opposed to the worldly

exterior world. The suffering body entrusted to acupuncture is in contrast to a separate spiritual inner sphere that is distant from the body: the flight from pain and the abandonment of the world seem to be completed. The next is *conquest*. In its etymology, conquest is related to going in search insistently. It means both taking control of something with force and with arms, as well as obtaining something with effort and difficulty. Lastly, let us recall the sense of seducing, making someone fall in love. This subject who has separated himself from pain and from the world, free but also empty, has to take possession of something again. Later we find *growing*, which in its root is related in Italian to creating, and which means becoming bigger in a natural process; figuratively, improving, making progress. One has been freed from profound pain but one also feels emptied out; now one seeks something to take control of, in order to grow. The next word, *magic*, evokes the ritual practice of tending to act through the occult arts on the nature of man. The effort of conquest and of growth is associated with a magic act, a transforming act that will not submit to the laws of reality. We return to the fantasy of by-passing reality, already found in the split between suffering confined to a body and entrusted to others, and taking refuge in an empty spirituality. The cluster seems to express the difficulty of seeing relationships: between emotion and suffering, between one's own inner sphere and relating to others, between patient and therapist. The word *autonomy* follows, composed of *autos*, himself, and *nomos*, law. This means controlling oneself alone, based on one's own laws, freely sanctioned; it means independence, freedom to think and act. In this sequence the desire for autonomy seems to express all the difficulty that one encounters in this cluster if one thinks of relating to someone, a person that one needs, that one asks for something, with whom to share something. Then come *difficulty*, *path*, *transform*. The subject continues to tend towards something, towards change, amidst difficulties. The term *unease*, which concludes the cluster, opens the possibility of representing the outcome of a therapy as a state that is different from calmness; not the extraneous profound pain that threatens and frightens which we find at the beginning of the cluster, but an acceptance of upheaval, problems and questions. In this RC, too, a psychotherapy process seems to be offered. In this cluster, placed on the opposite side of the second factor, there is a contrast between the psychotherapist's idealised power, typical of RC 1, and a sort of self-centered isolation. The patient that is represented seems to be isolated in his fantasies of liberation from pain and from constraints, of being autonomous from the relationship and from the context. The beginning of the RC seems to hope for liberation from suffering, from the confusion of obscure, invasive emotions through the split between the pained body entrusted to others – the only reference to the psychotherapist – and a spirit that evolves and makes conquests. However, in conclusion, or if you like, on the edge of the cluster, a more complex research emerges, that accepts difficulties, a pathway, and unease.

Cultural Repertoire 2

Father, mother, relationships, husband, children, sister, brother, family. The first part of this RC lists the members of a family. The second seems to evoke the ties that bind them: *aggressiveness*, to attack with violence. *Attack* has a similar sense but in Italian also means adhere, be united. *Crisis*, a state of upheaval, of sudden change. *Separation*, dividing, detaching, distancing things or people that are united or close. *Suffocate*, prevent from breathing temporarily or until death, repress something to prevent it manifesting and developing. What is evoked is a family relationship that swings between suffocating closeness and the need to separate and differentiate oneself. The cluster terminates with the word *security*, a term that seems to be in contrast with the whole dramatic sequence that preceded. But what sort of security is it? One might think that what suffocates gives a sense of security, because what binds protects one from choosing. The relationships evoked are all part of family roles. They are the relationships that are seemingly taken for granted and have no need to be desired and chosen in order to exist. The relationships, in other words, is experienced as given, and the emotion of mutual obligation takes the place of conscious choice and investment, generating fantasies of possession and violence. But also, in their

obviousness and their sense of duty, one can perceive security. It is the security of a sense of belonging that is obvious and compulsory, which nothing can seemingly infringe. In this cluster, situated on the second factor, what has vanished is the therapeutic relationship that was present in two different ways: central for RC 1, denied in RC 3. In this RC the other person in the therapeutic relationship, the psychotherapist, has disappeared because in a relationship based on mutual possession differences cannot be tolerated. There is only the family, or rather, the violence innate in family relations. It would seem that it is the evidence of violence in these relations that calls for the psychotherapist's intervention. Such an intervention, moreover, does not seem to make a difference in the dynamics of the relations of closeness and break-up found in the family: the psychotherapist seems to be engulfed in them. In addition, it is interesting to notice that the family seems to be the only context of social relations outside the psychotherapeutic relationship in the patients' whole cultural sphere. There are no other contexts of living together like work, school or other gathering places, which were however present in the texts of the interviews. None of these other contexts, on the other hand, can be seen to feature a fantasy of the obviousness of the relationship in the same way that occurs in the family, at least in our culture. Remember that the family is often compared to a "natural" context, where there is no decisive process of choosing to be together. This RC seems to represent a culture of relations that are taken for granted and compulsory in their obviousness, not based on processes of construction and choice. They are relations that as such suffocate to the point of death, but at the same time give security, triggering a process in which adhesion alternates with separation, seemingly with no alternative.

Summing up the patients' local culture.

Let us remember that on the first factor there is the contrast between RC 2 on the positive side, RC 1 and 3 on the negative side. On the second factor there is the contrast between RC 1 on the positive side and RC 3 on the negative side.

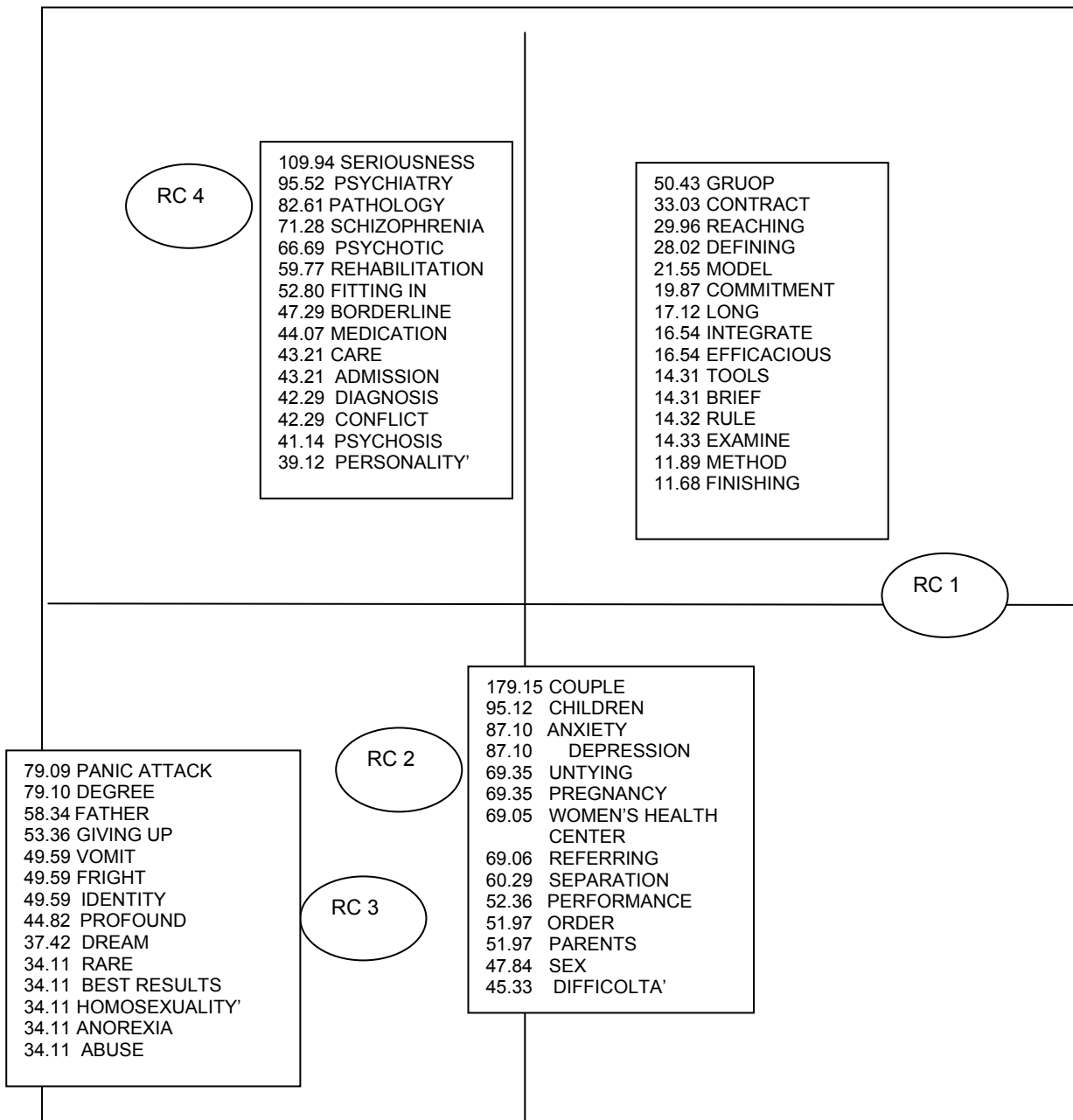
The *second factor* brings the psychotherapist-patient relationship to centre-stage. On the side of RC 1 we find the power of the psychotherapist, made omnipotent and identified with the controlling, resolving power one would like to have over one's problems. On the side of RC 3 we find the persecutory force attributed to the emotions, therefore to the relations arousing them, including that with the psychotherapist. The patient talking in this culture is isolated in his omnipotent fantasies of liberation and autonomy. The two poles seem to propose on the one hand an experience of control of the emotions (RC 1), and on the other the split between bad, unknown emotions and good emotions like conquest and growth (RC 3). These are the emotional experiences that can underlie the psychotherapy demand: controlling the emotions, freeing oneself of them in omnipotent fantasies doomed to failure, which prompted the request for intervention. Along two different pathways, the two RCs therefore offer, in their unfolding from the center to the edges of the cluster, an evolution of these fantasies, finally disappointed, only to achieve a recognition of the limits of reality. This process seems more articulated and complete in RC1 than in RC3. It would seem that in RC 1 there has been more work done on the fantasies experienced in the patient-psychotherapist relationship.

The *first factor* proposes the relationship between the patient and his living contexts. On the side of RC 2 there is a given context in which the relations are taken for granted as unquestionable and compulsory. These relations require no relational competence for their basis and their organisation, they are in fact given. It is just a matter of "accepting" or "not accepting", to be possessed by these relations or to withdraw from them. And it is in fact in this alternation between adhering and separating that the emotionality of the cluster lies. All this suffocates and at the same time gives security. One does not experience the risk typical of relationships that are not accepted unless they are constantly offered, agreed on, maintained. Emblematic of this obvious, suffocating and reassuring mode of relating is the

family. In this cluster there is no pathway starting from the acted out fantasies, in this case on relations based on possession, which are then thought out in some way, as happens RC 1 and RC 3. The whole cluster in fact seems marked by the acting out of the fantasies which distinguish it, without an alternative being provided. In this case the omnipotence of the fantasies does not meet the limits posed by therapeutic work. On the opposite side from the first factor, we find the psychotherapeutic relationship just as it is represented by RC 1 and 3. This relationship sees the opposition between one side (RC 1), where there is the dependence on a power that has resources one wishes to benefit from by identifying with it and becoming like it, and the other side (RC 3) with the reaction against a threatening power that one wants to escape from in an act of liberation and identification. However, despite the differences between RC 1 and 2, in the second factor the relationship is not given, but constructed starting from the problems posed by the fantasies that preceded it. In this relationship, the conflict and disappointment of fantasies is faced, and the fantasies, as well as the relationship itself, are reorganised. For the present we can conclude that the left-hand pole of the first factor does not correspond exactly to any cluster. Let us try to work out what kind of culture would be found in the place of the “absent” cluster. We can think of the patients’ life contexts, present in the interviews, but missing in the cultural space: examples are work and study. The things said on this point did not find a cluster, or cultural organisation that grouped them together. Their meaning is lost in the factorial space. We can see that such contexts, in contrast to the family, which characterises the right-hand pole of the second factor, would need to be constructed, or in other words, to be substantiated by choices and plans. Let us now analyse the culture of the psychotherapist group.

The local culture of the psychotherapist group

The analysis produced four RCs distributed over a space constructed of three factors. We give a diagram of the factorial plane below. The first two factors are represented by the horizontal and vertical axes. The first two factors are represented by the horizontal and vertical axes. The third has to be imagined as being perpendicular to the plane. In each cluster the dense words are ranked according to the decreasing value of χ^2 .



RC 4

109.94 SERIOUSNESS
 95.52 PSYCHIATRY
 82.61 PATHOLOGY
 71.28 SCHIZOPHRENIA
 66.69 PSYCHOTIC
 59.77 REHABILITATION
 52.80 FITTING IN
 47.29 BORDERLINE
 44.07 MEDICATION
 43.21 CARE
 43.21 ADMISSION
 42.29 DIAGNOSIS
 42.29 CONFLICT
 41.14 PSYCHOSIS
 39.12 PERSONALITY'

50.43 GRUOP
 33.03 CONTRACT
 29.96 REACHING
 28.02 DEFINING
 21.55 MODEL
 19.87 COMMITMENT
 17.12 LONG
 16.54 INTEGRATE
 16.54 EFFICACIOUS
 14.31 TOOLS
 14.31 BRIEF
 14.32 RULE
 14.33 EXAMINE
 11.89 METHOD
 11.68 FINISHING

RC 1

RC 2

179.15 COUPLE
 95.12 CHILDREN
 87.10 ANXIETY
 87.10 DEPRESSION
 69.35 UNTYING
 69.35 PREGNANCY
 69.05 WOMEN'S HEALTH
 CENTER
 69.06 REFERRING
 60.29 SEPARATION
 52.36 PERFORMANCE
 51.97 ORDER
 51.97 PARENTS
 47.84 SEX
 45.33 DIFFICOLTA'

RC 3

79.09 PANIC ATTACK
 79.10 DEGREE
 58.34 FATHER
 53.36 GIVING UP
 49.59 VOMIT
 49.59 FRIGHT
 49.59 IDENTITY
 44.82 PROFOUND
 37.42 DREAM
 34.11 RARE
 34.11 BEST RESULTS
 34.11 HOMOSEXUALITY'
 34.11 ANOREXIA
 34.11 ABUSE

Relation between RC and factors

RC	Factor 1	Factor 2	Factor 3
1	.648	.012	.035
2	-.469	-.558	-1.113
3	-.614	-1.174	.895
4	-.593	.651	.135

On the first factor, RC 1 on the positive side is opposed to RC 2, 3 and 4 on the negative side. On the second factor there is RC 4 on the positive side and RC 3 on the negative. On the third factor we find RC 3 on the positive side and RC 2 on the negative. We will give a reading of the local culture by analysing the four RCs that make it up.

Cultural Repertoire 1

The first word is *group*. A set of things or people gathered together so as to be able to see each other and almost consider themselves a single entity. The etymology is related to amassing, agglomerating, piling up different things of various origins. Group is also knot, intertwining. Here the psychotherapy session begins with a set of people enveloped, united, knotted together. The group meets with *contract*, from the Latin *contractus*, bring together, unite. The meaning also extends to the meeting of a consensus, and so contract applies to establishing something between the parties through an agreement. The cluster starts with a variety of people who come together also by means of an agreement. The knot, the confused pile produces differences that make an agreement. Then comes *reach*. Getting to join someone ahead on the path, managing to touch something. In a figurative sense, attaining something. A variety of people come together, making an agreement, and they commit to reaching something further ahead in the future, but also in a perspective of progress and development. A set of people want to attain something. Then comes the word *define*: from the Latin *definire*, which is at the same time marking out the limits, but also putting an end to, finishing. A group that has made an agreement to go ahead and develop, stakes out the boundaries of this quest. For the development and the quest to take place they must be staked out, their limits must be established. Then comes *model*. Model is the diminutive form of the Latin *modus*, meaning measure. This is the shape on a small scale of what one wants to do on a large scale; it is the prototype on which the pieces of a planned work are cut and forged. The model is the theoretical orientation used by psychotherapists to regulate their praxis. A model is necessary to set a direction forward and at the same time to mark out the limits, as a form of reference to provide criteria for progress and conclusion. Next comes *involvement*. Committing all one's efforts and capacities into achieving something, taking a stance. Next is *long*. The people associated in the intention to achieve something, after the effort of defining it and establishing the limits of the pathway with the help of a model, find themselves sharing a commitment, using their force to the utmost. But for how long? How long will the process be? The first feeling is of a great duration, a long commitment. Then comes *integrate*. Integral: that which lacks nothing. Integrate: to complete by adding what is lacking, to enrich. Bring a person into a new context so that he can cooperate. The people involved in the effort together confront each other with a feeling of loss, the work done needs to be enriched and completed. The differences in the group are not all eliminated by the original contract but have to be continually integrated. Then comes *effective*: that which has the strength to produce a certain effect. The group starts to compare the results of its work. Next is *tools*: everything used for work. This is followed by *brief*: again there is the question of time; the work is long, but the need for brevity must be taken into account, the cost of time.

Then follows *rule*, *examine*, *method*, and *finish*. What is evoked is a method, an orderly way to attain a goal, and the rule, related to ruler, the tool used to draw straight lines, or the rule

that regulates a practice, a discipline. The rule and the method help to finish the work, compared to the desire to examine things in depth and to continue. This cluster offers a tiring, committed labor shared by a number of people, where there is both the desire to go ahead and the problem of defining the relationship between people, the goal, the tools to reach it and the criteria to judge the finished work.

Cultural Repertoire 4

The first dense words of the cluster is *gravity*, followed by *psychiatry*. Something is grave if it has considerable weight, both in material and metaphorical terms. In a figurative sense it is something that is heavy to bear, and intolerable. But it is also important in terms of its weight, solemn and majestic. A grave act requires considerable responsibility to perform. A grave illness involves danger to life. Gravity recalls both intolerability and importance. The cluster opens with the diagnosis, therapy and prevention of mental illnesses, or psychiatry, seen as an activity related to events that are intolerable and at the same time important. In their gravity and weightiness, such events are able to confer authority to the practice of psychiatry itself. Next comes *pathology*, or discourse, *logos*, on illness, *pathos*. The discourse concerns the illness, that is the alterations in the body's functions. Figuratively, the pathology signals the alternation of equilibrium, and the state of negative crisis. Pathology of the body, pathology of a system. What is intolerable and at the same time important is the alternation of equilibrium of the body but also, as we shall see, of systems of living together. Remember that equilibrium is the state in which different forces compensate each other, reaching an ideal state which we try to come back to if something upsets the equilibrium itself. Next comes *schizofrenia*. This is from the Greek *schizo*, split, and *phrenos*, brain. Split describes what is broken, fissured. A brain is split, an equilibrium is profoundly altered. Next is *psychotic*, the degeneration of the psyche. *Rehabilitation* follows. In Italian 'abilitare' means make someone capable of doing something, as well as legally recognise him as being able to do something. The word also has the meaning of triggering a device, placing it in a position to perform certain functions. The important, intolerable problem that psychiatry is called on to handle is the rehabilitation of the broken equilibrium of a brain, and of a mind. *Inclusion* follows. The Italian 'inserimento' comes from *in*, inside, *serere*, intertwine, connect, tie together. Insert. Put one thing inside another. Get in, become part of; for instance, become part of a conversation. Rehabilitation involves reactivating the working of a mind, a brain, but also bringing back into a social context the person who, because of the equilibrium of the mind being interrupted and broken, moved away from this context. Next comes *borderline*. Being on the edge, on the border, being in a shaky equilibrium. This state is between being inside and staying outside reality, between being inside and outside sociality. Then there is *medications*. Medication: substance endowed with such properties that it determines changes in physiological functions. The intervention of psychiatry on the brain-mind that has lost its equilibrium is performed through being brought into a context that welcomes back those who have lost their social ties, and through medication, a substance that acts on weakened systems. This is followed by *care*, thoughtfully and attentively look after someone, fight an illness with therapeutic means. Next is *admission*, (in Italian 'ricovero' from 'ricoverare', bring to safety, and shelter). Then there is *diagnosis*, from *dia*, by means of, and *gnosco*, cognition. To know, by means of observation and tests, the nature and the seat of an illness. In an extended sense, to analyse a phenomenon based on its characteristics. Then come *conflict*, *psychosis*, and *personality*. The cluster that starts with the words gravity and psychiatry is the cluster of the intervention as an action that modifies not only behaviors but also contexts. The actions are those of rehabilitating a person who has lost his tie with society, of re-activating the functions of a brain or a sick mind, of bringing him back into the social context or admitting him to a safe place. The action needs a correct diagnosis to legitimise it, whether it takes the form of the administration of a medication, or activates contexts *ad hoc* for the person who suffers the breakdown of mental equilibrium. Remember that the psychiatric intervention can also be done without the patient's consent, and that often it is based on identifying an agreed goal with him. For this

reason, to be able to act even without the patient requesting it, the gravity that opens the cluster has its importance. In other words the problem posed by the patient must be intolerable and important not only for him, but also for the social context from which he has moved away and which must sanction an action taking place without his consent. Remember also that RC 4 is opposed on the factorial plane to RC1, which is the cluster of the construction of the relationship within a contract, and the identification of an objective shared by psychotherapist and patient.

Cultural Repertoire 3

The first instance of dense words in this cluster is between *panic attack* and *degree*. One is overcome by panic, a violent, uncontrollable fear. In Greek mythology, it was thought that what aroused the fear was the sudden appearance of Pan, the god of the woods, from the wild uncultivated areas far from known, cultivated sociality. 'Attack' derives from the Celto-Germanic root *tac*, to hook. A violent emotion, perceived as being extraneous, coming from outside the self, assaults and takes hold of someone, terrorising them with its strangeness. Panic attack is an expression of a technical language, typical of linking behaviors considered pathological to the categories of the DSM, the Diagnostic and Statistical Manual of Mental Disorders. It should be noticed that the panic attack, as it is generally defined, brings together and mixes physical and mental feelings, facts and experiences. Without any emphasis on the categorical discontinuity, we find alongside the fear of dying, for instance, shaking and cold sweats. At the same time, the technical term "panic attack" has entered common language, giving the layman a term to use when he wants to talk about violent emotions that he does not understand and that he sees as split, other than self. The patient who does not grasp the symbolic sense of his emotions, who attributes them to a physical state, will talk about panic attacks. A degree is a doctoral qualification legally recognised in Italy, giving one the right to practise a profession. The cluster begins with a clash between an intensely significant life event, like entry into the world of work, and facing the difficulties involved, and a fear that appears unmotivated and to be treated as a disorder rather than something giving information about one's state of life. Degree and panic attack are at the same time alongside each other and separated. Next comes *father*. A man that has generated children, but who also has the right-duty to bring up the underage children. Remember that it was only with the 1975 family law reform that the duties of the father and mother were made equal, with the abolition of paternal power and the introduction of parental power. Such power meant that power was attributed to a subject, in this case the father, so as to protect the interests of another, the child. When a child is overcome by terror in facing the problems of adult life, a father is called to the rescue, behaving as if the child were a minor. The father can protect and rebuke, threaten and encourage a child who does not obtain his degree, as well as guaranteeing him that he will protect him from the problems that may arise. Next comes *give up*. Putting something aside, interrupting, suspending something temporarily or forever. One would like the panic attacks to stop and for everything to go back to the way it was before. But making things go back to the way they were also means going back compared to the process of growth that is leading to the degree and to the threshold of the first job. There is a clash with violent unknown emotions, with a strange, devastating panic. One returns to the father, one considers giving up, interrupting the process underway. Next comes *vomit*: the act of bringing the contents of the stomach up through the mouth. But one also, for instance, vomits rage, by name-calling. Something inside that could be assimilated and become nutrition and part of us, is rejected and thrown out. It is not a thing experienced as a friend, but perceived and expelled as an enemy. The panic and the extreme, violent emotions are followed by vomiting, where they are violently pushed away from the self. Notice that like the panic attack, vomiting may appear to be a behavioral disorder, split from the symbolic sense that vomiting involves. In the cluster violent emotions continue to follow each other, split from their symbolic meaning, assimilated to bodily events. Then comes *fright*, (the Italian 'spavento' from the Latino *ex-pavere*, shake with fear). Sudden violent fear, caused by the feeling or the sight of a danger or damage.

Panic, extraneous and inexplicable, is replaced by fright. Unlike a panic attack, which confuses physical and mental events, fright is clearly an emotion. Moreover it is not explicable but can be linked to a danger. A distinction is re-established between the inner and the outer world, between facts and experiences. At the same time, there is the possibility of reconnecting the emotion to a context and to a meaning. Next is *identity*, referring to the set of physical and psychological traits that make a person what he/she is, different from every other person. The feeling that emotions belong to us and that they have a possible meaning enables us to reconstruct an identity and to recognise ourselves. Then comes *profound*, that which penetrates or remains far down, as opposed to vomiting and expelling. Next there is *dream*, the fantasies that the mind expresses when daytime life activity is suspended during sleep, and also *rare*, not common. After the expulsion of emotions, and their non-recognition, thanks to fright one re-appropriates an identity, a profound inner life, of one's dream, of one's rare, unique specificity. This is followed by *best results*. The result is what emerges as the conclusion or final outcome of a process. In Mathematics, it is the number or the formula that solves an operation or a problem. Best is the superlative of good and synonym of excellent or perfect. The best results are what would be expected by the father worrying about his child who is slow to graduate and who has the panic attacks that opened the cluster. The emotionality typical of this cluster seems to oscillate between the solution-expulsion of the emotional problems that lead to the request for psychotherapy, and the possibility that such problems will be recognised and integrated in one's identity and one's history. It could be said that it is not clear whether the client is the concerned father, or the child experiencing the panic of graduating. If it is the father, that is, a third party that assesses the psychotherapy process, he needs visible best results. If it is the child, the result is his identity, knowing who he is, finding an adult identity. If we take the child's perspective, that of a person bringing a problem to the psychotherapist, best results have no meaning; the child will have results that can be interpreted in the symbolic perspective of the "profound", of the "dream", of the complex meanings that the mind gives things. If we take the father's point of view, that is, of the bodies controlling psychotherapy outcomes, corresponding to the need to catalogue behavioral disorders, to which the DSM responds with the category "panic attack", then best results that can be shown to a third party are indispensable. There emerge two different outcomes of psychotherapy, two conflicting ways of assessing its usefulness: best results related to giving up, detaching oneself from disturbing emotions that cause dysfunctional behaviors for the father, and the identity related to integrating emotions, giving them meaning, for the child. Next come *homosexuality*, *anorexia*, and *abuse*. Yet again there are behaviors which from a certain psychotherapeutic perspective can be read as a disorder or source of disorders to be corrected to pursue best results, while in another perspective they can be linked to the symbolic sense given to them by those who experience them.

Cultural Repertoire 2

The cluster starts from the word *couple*, from *copula*, tie, joining. Two people carrying out the same activity in a coordinated way, two people tied by a relationship. Next is *children*. Those who are generated by the couple. The activity of the couple is to have children, their relationship is based on looking after the children. People have been bound together by bonds of biological consequentiality: parents generated children and they are therefore together as a couple; children have been generated by a couple, and they are therefore in a relationship with the couple. Next come *anxiety* from *ango*, squeeze, suffocate, and figuratively tire, make anxious. Anxiety is a state of agitation motivated by uncertainty and trepidation, it is fretful desire, it is an emotional state akin to anguish. The biological tie has its symbolic emotional connotation. How do the members of the couple feel about it, how do the children generated by it feel about the relationship between themselves and with the couple? The first feeling is that of being constrained, cramped, suffocated. Here we find a feeling akin to that found in RC 2 of the patients' local culture, the same experience of obvious, suffocating ties associated with the family. Next comes *depression*. From *premere*,

plus the emphatic *de*: press, lower, but also humiliate, demean. Physical and psychic prostration bringing tiredness, melancholy, bad mood, pessimism, and lack of confidence. Depression is also a psychiatric category describing a mood disorder, for which a biological basis is sought and which involves pharmaceutical therapies. Next comes release (in Italian 'vincolo' comes from *vincire*, tie, knot). Release is freeing oneself from something binding that hinders movement. One reacts to a tight suffocating bond with the desire to get free. Next there is *pregnant*, gravid (the Italian '*gravidanza*' is from *gravis*, that has weight), the woman's state from fecundation until birth. This is a human event that brings with it a great deal of biological and cultural consequences. The pregnancy will give rise to children. The cluster seems to insist on biological ties and on the complexity of their transformation in the event of living together and socialising and in symbolic events. Next comes '*consultorio*' or *women's health centers*. Consulting: ask someone for advice, an opinion, an answer. In Italy the service of women's health centers was set up in 1975, in an atmosphere of great social transformation, closely related to the feminist movements of the time. They were created to be multi-disciplinary, non-directive, focused on women's needs. These services were however divided right from the beginning between a culture of consultancy, at the service of the users' problems, and one of directing, giving directions and orientation. The latter tendency would become clear with the appearance of Catholic women's health centers. In the meantime the cultural, institutional and political context has undergone profound changes. On this point, in the '80s women's health centers became part of the National Health Service, with the strong risk of losing their social role in favor of a health role. They therefore become a place of exchange and confrontation between the aims of treatment and rehabilitation on the one hand, seen in a mainly medical perspective, and the goals of prevention connected to the rejection of biological reductionism, on the other hand. In relation to the latter aims, however, no perspective alternative to the medical one has gained an effective dominance. The issues in contention include verifiable and measurable goals of the praxis adopted. These goals seem possible to pursue in the medical perspective and are missing in the preventive perspective, which undermines the latter position⁶. It should be remembered that the psychotherapy intervention is seen as being problematic in the activity of women's health centers, where it takes the shape of a medicalised specialist intervention in contrast to the intended espousal of the women's health centers' original principle of the complexity of the demand. Next comes *refer*, put on the road, send. Sending something to a specific place. Make someone go, send someone with a precise commission. Put on the path, direct along the right road. People linked by biological ties, in search of an emotional and symbolic meaning of their relationship, go to a consultation in a public service and are referred, or directed to another place, and on the right road. Next is *separation*. From *se*, particle that indicates division, and *parare*, put on a par. Sunder or divide united, close, mixed or confused things, elements or substances. Distinguish, but also make discordant. Relatives, those joined by a generational tie, are directed along the right road by the consultation and are helped to separate and distinguish themselves from each other. Separating is a mental position of differentiation from the other person with whom one is mixed up, or it is an action, a breaking up of the relationship. In this cluster it is not clear how much space there is for giving a symbolic meaning to what happens in relationships of the patients being dealt with, or how far actions are performed for them; for example, giving consultations and support for a couple to separate. Next comes *performance*, in Italian from *prestare*, be ahead. Place at disposal, provide, hold out. The performance is to supply one's work to carry out a task or an activity, but it is also the way it is carried out. Performance also refers to how well a machine goes. The consultancy provided in this culture is organised around an activity: referring, separating, performing. Performances are substitutes for the competences the user does not possess. For instance, information is provided about what one does not know. It is different if the consultation is integrative, when one works with a client to help him to develop a competence; for instance working on the way he symbolises being informed on an issue, the relationship with the person who might

⁶ For a short history of women's health centers, see Grandolfo (2002).

inform him. Next come *order*, *parents*, *sex*, and *difficulty*. It is reiterated that the parental couple are the protagonists of the cluster, as well as the need to bring order into the relation with sexuality, a possible source of disorder.

Summing up the psychotherapists' local culture

If we adopted the language of psychotherapy research, we would say that the first factor, which sees RC1 on the right side, offers a culture of process, or of relating and the way the relationship is organised during psychotherapy, and that the second and third factors, on which the other RCs are situated, represent the culture of product, or of the solution of problem behaviors. The interesting aspect is that these cultures are not presented as being integrated with each other, but as being opposed. It could be said that for RC 1 the process is the product. Outcome and process coincide because the outcome is an acquisition of competence in the process, in relating. The outcome is learning to relate within limits of reality, i.e. within the limits of the consensus, the result, the verification of what is done together. It is the cluster in which the relation and its process of getting organised is at the same time the method of working and the result. This can be understood if it is thought that a person who requests psychotherapy has problems relating. For the other clusters, the relating is acted out, not analysed. The intervention is an action designed to modify behaviors, the results are related to this modification, and the outcomes are more important than the process, or if you like, than the relationship. There are some interesting contradictions, as we shall see. RC 4 is related to the psychiatric intervention in serious cases, where the intervention takes place without the patient's consent. Here we are looking at rehabilitation and re-entry, at least within the limits of what is possible; beyond these limits there is admission to hospital. The fact that the service and the resources and decision-making power it can mobilise are indispensable, shows how crucial its action is in the psychiatric intervention. In RC 3, as opposed to RC 4, the psychological intervention is medicalised. Problematic emotional dimensions are split and lose their symbolic functional significance to become disorders to eliminate, behaviors to give up. The symptom is no longer information, but a deficiency to solve. All this happens in an intervention that envisages a third element, the controlling agencies outside the psychotherapeutic pair requiring different results. External agencies – the fathers, whatever form they may take, be they insurance companies or the scientific community – expect “best results”, while the cooperation between the pair could result in the reappropriation of emotions by the patient and the reconstruction of his identity. RC 2 offers a culture close to and at the same time remote from that in RC 3: here too there is a third element which expects results and performance but which is not outside the therapeutic pair, namely the psychotherapist-women's health center. With it we evoke all the services and the components of similar services, in its contradictions between the mandate responding to the controlling agencies and its consultation role for the clients. In the women's health center there is conflict between the intervention as substitution or integration, between intervening on behaviors and providing consultation favoring a symbolic construction of living together within the biological and family bonds.

A comparison between psychotherapists' and patients' local culture.

Before our concluding remarks we wish to give an introduction. For the psychotherapists the three variables considered were sex, years of experience and whether they worked mainly in a public or private context. For the clients, two variables were considered: age and sex. None of these variables, for either of the cultures, proved to be significantly related to the cluster. This means that the cultures apply across all the subjects, both psychotherapists and clients. Therefore if we talk about different kinds of services, as far as the psychotherapists' culture is concerned, we are not saying that in those services there is that

particular culture, but that when the psychotherapists interviewed talk about that culture they associate it to those services.

The *psychotherapists'* culture is organised along two lines: the intervention models, and the fields of reference of the psychotherapists themselves.

Intervention models can be related to:

- work on the relationship and on the experiences connoting and organising the relationship (RC 1).
- behavioral modification (RC 4, RC 3, RC 2).

The fields of reference seem to be:

- the psychiatric services, in which the intervention is mainly a substitute for the patients' lack of competence (RC 4).
- the services which take a social health approach, with the clash and the combination of interventions (RC 2).
- the agencies controlling psychotherapy praxis, today constituted by a strange mixture of scientific community and agencies providing funds and resources, like insurance agencies (RC 3).

Let us see how intervention models and fields of reference combine.

In RC 3, the cluster linked to the agencies controlling psychotherapy praxis, the intervention seems to be divided between work which considers the symbolic aspects of the symptoms presented by the patient when dealing with the contract with the patient, and work where the symptoms are medicalised and solved in order to certify "excellent results" to be shown to controlling agencies, when dealing with the latter.

In RC 4 the action commissioned seems to be related to the social mandate calling for rehabilitation and re-inclusion of the mentally ill person in society; this mandate legitimises the intervention as a substitute for the patients' competence.

In RC 2 the action commissioned seems to be related on the one hand to the users of the service and to their requests for the development of competences, such as parenting skills, and on the other hand to the institutions represented by the services, such as those that protect the family and that want the service, as the operative arm, to be accountable for this protection. The result is an intervention divided between the two needs, which are not necessarily in agreement. The need to keep order is not the same as giving assistance to parents in difficulty. In this sense these services both meet and clash; in other words, some interventions are substitutes for clients' competences, designed to guide and orient the user, and others are integrative, designed to develop competences in the users.

Remember that on the factorial plane, RC 1 is contrasted to all the others. While in RC 4, RC 3, and RC 2 there are other figures commissioning psychotherapy intervention that overlap, clash or replace that of the patient, in RC 1 the action commissioned comes from the patient.

One initial comment: the more other, non-patient, figures there are commissioning the psychotherapy intervention, the more we find intervention models based on the action and modification of behaviors. When it is the patient alone that commissions the intervention, then the intervention is mainly based on the relationship and the analysis of the relationship. However, this relationship tends to become embedded in the psychotherapy setting, without this context relating to the patient's other contexts of reference. What seems to apply is the idea that if the patient's ability to relate in the setting grows, then his ability to operate in other contexts will also grow. Again, remember that psychotherapists working in the public domain and those in the private sector are distributed in all the clusters, and therefore in all the cultures being examined. This means that the presence - absence of non-patient figures commissioning interventions, when it occurs, is a collusive process, a culture, primarily a way of symbolically representing the psychotherapy context to oneself, before being a structural reality.

The *clients'* culture seems to refer to three representations of psychotherapy :

- RC 2: psychotherapy offering families counselling based on an intervention that acts on the dynamics of family membership and therefore on the relationships inside the family.

- RC 1: an intervention that works on the psychotherapeutic relationship analysing the experiences that characterise and organise it.

- RC 3: an intervention that works on the patient's inner world without examining either the therapeutic relationship or the patient's relation with his own context.

One initial comment: a split seems to present itself between the patient in relation to his social context, represented by the family alone (1 factor, RC 2), and the patient in the psychotherapeutic setting (2 factor, RC 1 and RC 3). If we consider that the family is offered as a relational context dominated by the dynamics of belonging (being in – coming out), we see that patients' experience in relation to psychotherapy lacks any expectation of development of skills for being in productive contexts. Such contexts, as well as having the goal of constructing membership, the relationship also aims to transform states of reality with competence. Let us try to connect the two cultures.

- The psychotherapists' RC 1, centered on the work of relating and on the experiences that typify and organise the relationship, can be linked to the clients' demand as it is represented in the RC 1 of the clients' culture; in this case the clients' demand is to acquire the skills to construct relationships.

- The psychotherapists' RC 2, centered on the problems of the couple and the family, can be linked to the way the clients represent psychotherapy to themselves in the RC 2 of their local culture. There is however an interesting difference. For the clients, acting in the dynamics of family membership, seen as violently constraining but also reassuring in its constriction, seems to be the only prospect considered. The psychotherapy intervention seems merely to support the formation and dissolving of the ties between the various members of the family, and is somehow enveloped in the dynamics of family membership, without seeming to bring any aspect of difference. In contrast, for psychotherapists there is a prospect of behavioral modification on the one hand and of intervention on experiences, on the other.

- The psychotherapists' RC 3 does not seem to have an equivalent in the clients' culture.

- The psychotherapists' RC 4 does not seem to have an equivalent in the clients' culture.

While the absence of RC 4 can be understood by considering that after being deliberately identified, psychiatric patients and their families were not interviewed, the fact that there is no client culture related to the psychotherapists' RC 3 gives the idea that the conflict identified in the psychotherapists' RC 3 does have an equivalent in the clients. They are not asking for deficit correction, but for the construction of identity.

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