Training aims and method: thincking emotions within the clinical relationship

by Renzo Carli[*] and Rosa Maria Paniccia[**]

PART I– THE CLINICAL FUNCTION IN PSYCHOLOGY

Introduction

Here is one of the answers the editorial staff of *Architectural Digest* got when interviewing some of the most renowned European designers:

"When I begin with a new client, I always Like to know them better. I invite them to the Kanaal, our complex in Antwerp, and to our castle, and then we'll have lunch. I ask them a lot of questions about what they like and don't like, how they live, how many children they have. When clients ask me to design their home, it's important that they feel completely at home when it's finished. Through art and objects, I want to make their portrait in their home. I want our clients to discover themselves. Normally, we become great friends with our clients. They need to love art, or they need to want to love art or be introduced to art. The artwork is very important in my interiors." (Designers Tell All – Axel Vervoordt, Architectural Digest, 1, 2008, 1-2).

Axel Vervoordt, the author of it, is a Belgian antiques dealer. As an interior designer, he decorates the homes of selected clients with one of the most sophisticated tastes in Europe, and he is the organizer, or better the creator, of outstandingly interesting and exquisitely elegant exhibitions. At the time we are writing, Palazzo Fortuny, in Venice, is hosting an exhibition called "In–finitum" (june - november 2009). It is the last part of a trilogy, which started with "Artetempo: Where time becomes art" (Venezia 2007) and had "Academia: Qui es-tu?" (Paris 2008) as its centerpiece. "In–finitum" is a complex and intriguing experience. The notion of *unfinished* – of the "left undone" as it is well known in the field of art – there blends with a more disquieting one, that of *infinite*, evoking for us the unconscious and the theories of Ignacio Matte Blanco.

The above piece of interview shows that, with his clients, Vervoordt initially carries out a sort of analysis of demand. He invites them to visit his complex (Kanaal) and his castle, in the vicinity of Antwerp; he has lunch with them and asks them everything about their family, their life, their tastes, and what kind of living space they would like their new home to be. He aims to make "their portrait" by redesigning the interiors of their homes, and to help them to rediscover "themselves" We can still picture his subtly elegant figure strolling through the vast halls of Palazzo Fortuny (unfinished and infinite-evoking themselves) together with his American clients; we can see him showing to his friends-clients the different sections of the exhibition, lingering in front of Lucio Fontana's *Concetto Spaziale* (No. 59 T 148), admiring an "egyptian" head (*Isabel - l'Egyptienne*) by Alberto Giacometti, looking at the Bill Viola's video diptych called *Bodies of Light*.

But let us change the scenario now, and let us consider a person who is experiencing the following symptoms: severe dry cough, sharp chest pain, fever with chills, difficulty breathing, and rusty sputum with pus and blood. For this person it is clearly "mandatory" to see a doctor, and the doctor will most likely diagnose pneumonia. Such a diagnosis will only be made on the basis of the patient physical examination, and of the results of the laboratory tests that certainly the doctor will have ordered immediately.

[*] Full professor of Clinical psychology in the Faculty of Psychology 1 at the "Sapienza" University of Rome, ordinary member of the *Società Psicoanalitica Italiana* and of the International Psychoanalytical Association.

[**] Associate professor in the Faculty of Psychology 1 at the "Sapienza" University of Rome.

The two situations are markedly different from one another: in the first one, someone is asking a renowned interior designer to rearrange his home; in the second one, someone is complaining of worrisome symptoms and seeing a doctor in order to have the diagnosis, the prognosis, and the treatment strategy best suited to his clinical conditions. One might wonder what is the connection between the two situations, which we will call the "strategy to the problem" and the "strategy to the disease", respectively. One might wonder as well which one of them resembles clinical psychological intervention more. For most psychologist, the obvious and desired reference seems to be the one to the "medical model", according to which they are supposed to respond to the patient's "mandatory" demand. The clinical psychological approach we put forward is based, on the contrary, more on the "strategy to the problem" than on the "strategy to the disease".

The two strategies

It has to be considered, in the first place, the ground on which the "strategy to the disease" is based. Differently from what is usually believed about doctors, they don't really deal with pain, or with the relief of suffering. They deal instead with classes of pathogens and diseases, which can be treated because their description and classification came from the same scientific research that also produced diagnostic and therapeutic protocols. Pneumonia is not a "piece of reality" (Salvatore, 2006): the disciplinary object of medical intervention is rather a "template" or a "model", which is directly drawn from scientifical definitions.

It would be a serious mistake to compare a panic disorder or a psychological sexual disorder to pneumonia, and to try to treat them by means of the "strategy to the disease" - a mistake that, unfortunatley, is most frequently made in clinical psychological practice.
According to Sergio Salvatore (2006)[1], psychology tends to the reification of its own categories; in other words, it is inclined to deal with "psychological concepts not as with constructs, which construe the disciplinary objects in terms of models, but as with pieces/states/qualities of the world" (p. 122). Salvatore also pointed out that psychology, when it comes to its own definition, tends to select as its objects (as the objects of both its theory and its practice) phenomena which are supposed to be directly drawn from reality. "Such an inclination can ultimately be regarded as deriving from an epistemological approach of neo-positivist inspiration, that views the categories of scientific language as the precipitate of a controlled process of systematic organization of the experiential data" (p. 123).
More specifically, psychology (which puts itself forward as a profession that is able to address definite problems) has to face the same, serious, problem that psychiatry has to face with respect to medicine: the definition of pneumonia is rooted in specific etiological grounds (the inflammation of the respiratory system or of a part of it, i.e. the lungs, caused by a specific pathogenetic agent – be it a bacterium, a virus or something else), and the disease must be viewed in the framework of its own pathogenetic process (i.e. the response of the organism of a given patient to the inflammatory action of a given agent). Psychiatry, however, is not founded on etiopathogenetic grounds; let alone psychology. The latter profession, though, claims it can lean on psychiatry when it comes to define the problems it intends to address and to solve by means of its own specific professionalism.
If one fails to grasp the difference between the *narration* of a panic attack and the *diagnosis* of pneumonia, he will hardly be able to confer a scientific status to clinical psychological intervention. As we've already observed, pneumonia shows up as a cluster of *symptoms* (cough, fever, difficulty breathing, etc.), but symptoms alone are not enough: the diagnosis

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

also requires that the presence of a bacterial or viral infection is actually proved by particular *signs* and *evidences*. In other words, symptoms are merely a "pretext" for the patient's demand, a sort of alarm bell ringing, allowing medical intervention to come into play with its diagnosis, prognosis and treatment components. Let us consider, now, the DSM-IV definition of a Panic Attack – that one panic attack which, if unexpected and recurring, and followed by a persistent fear of more attacks, leads to a "diagnosis" of Panic Disorder:

A discrete period of intense fear or discomfort, in which four (or more) of the following symptoms developed abruptly and reached a peak within 10 minutes:
1. Palpitations, or accelerated heart rate
2. Sweating
3. Trembling or shaking
4. Sensations of shortness of breath or smothering
5. Feeling of choking
6. Chest pain or discomfort
7. Nausea or abdominal distress
8. Feeling dizzy, unsteady, lightheaded, or faint
9. Derealization (feelings of unreality) or depersonalization (being detached from oneself)
10. Fear of losing control or going insane
11. Fear of dying
12. Paresthesias (numbness or tingling sensations)
13. Chills or hot flashes

Patients suffering from panic disorder are often concerned that the attacks may indicate the presence of an undiagnosed, life-threatening disease. Others fear that the attacks mean they're "going insane" or losing control. To cut a long story short, they all are afraid to die. And this is interesting: one can be afraid to die during or as a consequence of a panic attack, but one can also have a panic attack because he is afraid to die. Often, in the latter case, the fear of dying has a real basis in personal clinical reality. There is some confusion in the matter.

Anyway, the reader will not have missed the "similarity" between the symptoms of pneumonia and the symptoms of a panic attack. In fact, the description of the latter can appear even more detailed. The difference is actually to be found in the underlying causes: whereas the symptoms of pneumonia can easily be ascribed to the lung parenchyma inflammatory response to viral or bacterial agents, the causes of panic attacks remain unknown. What is known in that they have to do with individual "lived experiences" which – thanks to an ambiguous use of language - are described or alluded to as a mix of inherently subjective feelings (e.g. "a fear of…") and sensations that are claimed to be objective (e.g. pain, trembling, shortness of breath, nausea, sweating, chills). In our view, the reasons for a panic attack can only be understood in the framework of the relationship between the person who talks about his disorder and the person who listens.
If pneumonia is a disease that can be, and must be, properly diagnosed and treated by a doctor, a panic attack is rather a "pretext" to communicate, to ask for someone's help - basically, to tell of one's own fear of death to someone who is willing to listen. Based on the diagnosis, doctors know how to deal with pneumonia, and thanks to the discovery of antibiotics such a disease is not life-threatening anymore. A "diagnosis" of panic disorder, however, only allows colleague psychiatrists, psychotherapists and clinical psychologist to discuss with each other and to share and compare the problems of their respective patients. Such a comparability, by the way, implies the loss of the symbolic and emotional dimension of the demand relationship.

Let us go back, now, to the two strategies.

When the "strategy to the disease" is used, the problem:
a - can be objectified thanks to its biological nature
b - can be known by means of specific procedures and models

c - subjectively originates from a symptomatic experience of discomfort
d - can be scientifically defined by means of rigorous, shared constructs (e.g. the lung parenchyma infection), which trace its diagnostic, prognostic and treatment boundaries
e - can be treated on the basis of its etiopathogenesis
f - treatment outcomes can be assessed not only from a subjective perspective but also, and most effectively, by verifying the presence of objective signs and evidences
g - for "suffering" people it is "mandatory" to seek for treatment, and treatment must be carried out by a qualified professional who is licensed to practice medicine

When it comes to the "strategy to the problem", someone resolves to ask an expert interior designer - such as Vervoort, as per the above example – for a rearrangement of the space and furniture of his home. The problem is not objectifiable, it is born out of the subjectivity of single individuals or social groups, and there is no rule whatsoever saying that to solve it one must ask for expert advice If you feel like changing your home, you can seek the help of an interior designer, visit an Ikea store, or leave everything as is. A mother who is afraid of being overly authoritarian with her adolescent son can consult a clinical psychologist, talk to a friend, or even pray the patron saint for illumination. A man who is suffering from panic attacks can ask a doctor for a sedative, talk to a psychologist, or go on holiday to forget his troubles. There is no code prescribing or advising that those problems which may lead people to seek psychological help should be solved with the aid of a psychologist. It's up to the professional to put forward his own expertise and prestige so as to motivate individuals and social groups to ask for his services - Vervoordt may well be regarded as a telling example of this.

It is the demand that has the power to *establish the relationship* between the person who makes the demand itself and the person to whom it is addressed. And the demand is based on the awareness, by the person who has a given problem, not only of being unable to solve it by himself, but also of the existence of a professional who is able to. Thus, the strategy to the problem implies a one-to-one correspondence between (the client's) expectation and (the psychologist's) expertise.

When the "strategy to the disease" is concerned, the problem:
a - is subjective
b - originates within the (family, work, or more generally social) relationship
c - is symbolically reproduced within the demand relationship with the psychologist
d - is treated by means of the relationship itself
e - the outcome of the intervention is "methodological", and it consists of a rearrangement of the emotional symbolizations within relationships
f - it is by no means mandatory to ask for professional help to cope with the problem; the demand made to the psychologist only stems from the expertise and prestige of the psychologist himself, and from the social awareness of a possible connection between that one problem and that one expertise

A proposed definition of clinical psychological intervention

The purpose of clinical psychological intervention is to establish a thought about the emotions which are evoked by the relationship and which are otherwise acted out in the relationship itself - be it organizational, familiar, institutional, or social in a broad sense. According to this definition, the clinical psychological function is aimed at facilitating and promoting, by means of the professional relationship, the replacement of acted-out emotions with emotions which are thought-about by the client, within his relationship with the psychologist as well as within the broader context of his social life and experience. Interestingly, this is not only the goal of the intervention, but also the methodology that allows such a goal to be achieved.

It has to be pointed out, though, that the process of thinking about emotions is not able per se to define a “problem” - not one which may be understood as such and as such turned into motivation for a clinical psychological demand, at least. When psychological intervention is characterized or defined at the start in terms of process – of this process - it proves most hard, in the following stages, to overcome not only the usual distrust toward a new and poorly known profession, but also the skepticism that is engendered by “problems” – such as unthought emotional acting out - which don’t seem to be really experienced as problems calling for psychological help. Emotional acting out is not perceived by either individuals or social entities as a problem; it can only become one in particular social circumstances. It rarely happens that a demand is made to a clinical psychologist based on the awareness that a problem arises from unthought emotional acting out. As a consequence, psychologists can only - and most laboriously - analyze emotions as they are acted out within the “problem areas” that more directly brought the client in: existential and social, as well as education-, work-, power- or efficiency-related difficulties; dissatisfaction with one’s current life, affective relationships, sexuality, or with the fulfillment of one’s plans, ambitions or dreams for the future.

However, clinical psychologists also need to somehow define and qualify their own skills and expertise, in order to enable potential clients to seek for their services. The reification of problems that has been pointed out by Salvatore can by understood when considering the hurried need to assign psychologists a “working area” On the one hand, by saying that they have the competence to treat “sexual problems”/“sexual disorders”, panic attacks/panic disorders, couple communication difficulties, depressive disorders, and so on – i.e. by the reification of a universally known facet of reality - clinical psychologists allow themselves to be defined as the professionals which are able to solve those problems. On the other hand, the urge to set the boundaries of specific problem areas, in relation to whom their expert image can be presented, significantly contributes to determine their poor credibility and actually confused image.

Facilitating a thought about the emotions which are evoked by relationships: this is the competence on which clinical psychological function is founded; and this is the path to take, in our view, when it comes to provide a definition for our profession.

The relationship as the basis of a thought about emotions

Clinical psychological practice, as we mean it, has the relationship as its objective, its method, and its test ground. This is the defining focus of the theory of technique that we have called “analysis of demand”. Clinical psychological practice is all contained within the relationship between the person who makes the demand for intervention, bringing the problem which motivates the demand itself, and the psychologist to whom it is addressed. Analysis of demand is based on three major points:

a – the problem posed to the psychologist is born within a dynamic process we have called “failure of collusion”; collusive dynamics pertain to the individual-context relationships of who makes the demand

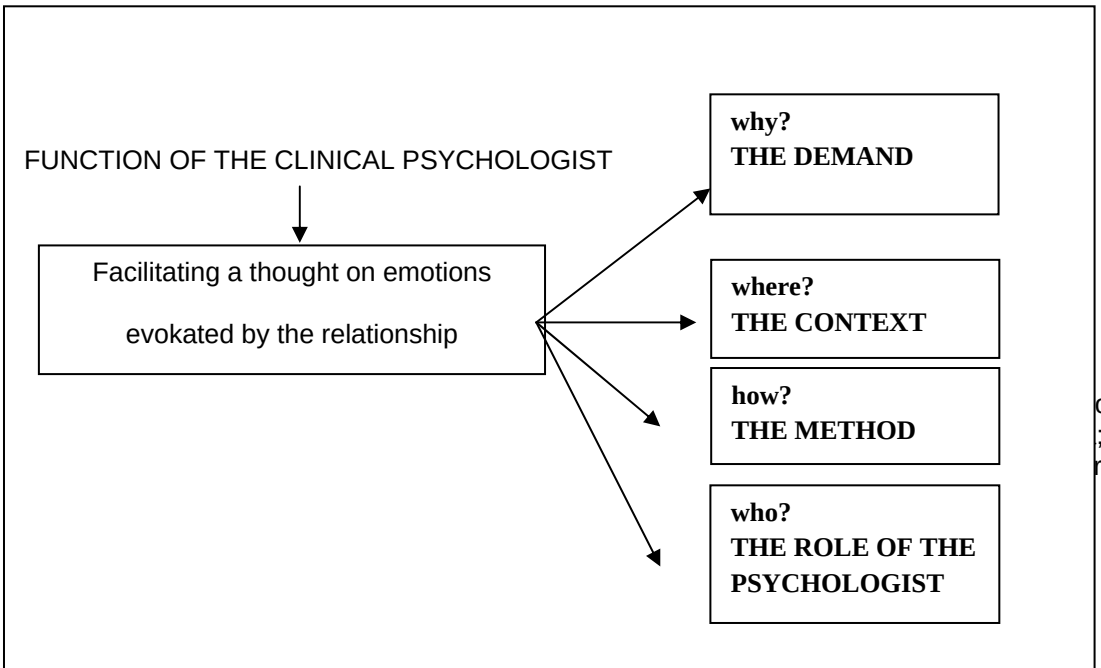
b – the relational problem is “reproduced” within the symbolic relationship between who makes the demand and the psychologist

c – the analysis of such a symbolic reproduction allows for the working out of a thought about the emotions which are experienced in the “here and now” of the demand relationship as well as in the “there and then” of the individual-context relationships; this, in turn, allows for the emotional rearrangement of the events that led to the “failure of collusion” and hence to the problem underlying the demand.

According to this hypothesis, which has been thoroughly explored elsewhere[2], the role of clinical psychologists can be seen as that of "facilitators of a thought about the emotions which are evoked by the relationship between the person who makes the demand and the psychologist". And the emotions at issue are those which are experienced, within the clinical relationship, by the patient as well as by the psychologist. The object of clinical work is the competence to "think about emotions"; more specifically, the competence to turn the emotions which are experienced within the clinical relationship into a thought which is able to steer action and to put *action* where *acting-out* was, i.e. where emotions were not contained but rather converted into immediate (not mediated by thought) reactions. When they are thought about, relational emotions organize themselves into "emotioned and thought-about fantasies"; when they are acted out, they lose any chance of being thought about, and they trigger instead a succession of action-reaction cycles which become more and more of a problem as responses are evoked in the other participant as well.

Such a role or aim of clinical psychology might appear reductive and repetitive at once. This is not the case, as the above definition implies a series of *specifications* of major importance. They concern not the individual problems of the person who makes the demand, but the relationship. The latter statement is not to be underestimated. As we have seen, two approaches can be used to define clinical psychological profession: in one case, the demand is "given", as it originates from problems which are supposed to directly "correlate" with psychological expertise; in the other one, the profession is founded on the construction of a praxis that is to be guided by the analysis of demand. According to the first approach, the psychologist accepts the demand "as it is addressed to him", and tries to solve the problem as it is posed by the patient. Such a result can only be achieved by means of techniques which are aimed at modifying behaviours and/or cognitive constructs steering them. In this view, psychologists define their own role in line with the problem as it is "given" to them: eating disorders experts treat anorexia and bulimia, "sexologists" treat sexual disorders, borderline personality disorder experts treat borderline personality disorders, etc. Professional specialization is thus directly related to the problem posed by patients. More generally, it depends on the psychotherapeutic technique used, i.e. on the chosen - behavioural or cognitive - school and orientation. What we have put forward is instead a professional orientation allowing the problems posed by clients to "meet" with a reference to the psychoanalytic theory of technique: in fact, analysis of demand is based on psychoanalytic theory, but it is not aimed at applying such a technique in order to carry out a psychoanalytic experience in its classical meaning (as in "to go into psychoanalysis", "to be in psychoanalysis", "to do psychoanalysis"); on the contrary, it has the purpose of understanding the symbolic emotional meaning of the problem posed.

But let us go back to the specifications regarding our definition of clinical psychological practice. They can be summarized as follows:



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In this view, there is essentially only one clinical psychological function - interventions differ in other respects, such as the demand that is analyzed, the context in which they occur, the method used, and the specific role played by the psychologist.

Why?

An intervention aimed at facilitating a thought about the emotions which are evoked by the relationship can be neither planned nor implemented if the demand - calling for and organizing the intervention itself - has not been analyzed first. It is within the analysis of demand that thoughts about emotions can develop and acquire meaning and maturational significance. Let us look at some examples.

A CSM (*Centro di Salute Mentale*, i.e. Mental Health Centre) in Tuscany accepted to take part in one of the research-intervention projects realized by our Chair of Clinical Psychology with the aim of fostering organizational competence in local mental health services. The various reasons underlying such an "acceptance" were hard to define precisely: there was an interest for a project that, commissioned as it was to the University by the Ministry of Health, seemed to suggest the possibility of an increased governmental attention to mental health issues; one of the psychologists working in the service had been trained, years before, in the School of Specialization in Clinical Psychology that had been headed by one of us; the relationships among the operators were difficult, albeit all oriented to pursue the service's objectives. The demand became clearer as the sessions progressed. In a role-playing session, six operators were asked to play out the collusive relationship among the nurses and the inpatients of a Group Home where the room of one severe patient had flooded from a broken pipe. This turned out to be of great help in understanding the relational problems existing between the operators and the patients as well as between the operators and the management, and the need for a specific competence to deal with the service's relational problems came out. As the role playing progressed, all actors were clearly faced on the one hand with the difficulty of understanding the emotions acted out by the patients, and on the other hand with the operators' tendency to "solve concrete problems" rather than to establish relationships which could have enabled a process of thought about the emotions characterizing the operators-patients relationship. Session after session, the work we were doing together took on a new meaning: all participants became aware of the actual problem on which the demand was based, and the reasons for the sessions themselves became eventually clear.

This goes to show that the demand has to be constructed in the course of the intervention. But it is the construction of the demand itself that needs in the first place a thought about the emotions which are being experienced within the relationship between psychologists and clients. Thanks to role playing, the CSM staff was allowed to understand the actual reasons

for its participation in an intervention whose explicit purpose was to improve the participants' organizational competence – the competence to develop, within a service, relationships which are potentially able to let the service itself achieve those aims which professional competence alone would not assure. The difficulty met by those operators in accepting the organizational counseling intervention actually reproduced the same problems that all operators usually face in their work with patients, be their service a CSM, a SPDC (*Servizio Psichiatrico di Diagnosi e Cura*, i.e. Psychiatric Service for Diagnosis and Care), a Group Home, a Day Centre, or a Therapeutic Community. Such a difficulty is inherent in understanding the major role played by emotions in work relationships. The acceptance of the sessions with the psychologists as a mere duty – nothing more than an acting out of the ambivalent emotions experienced toward the proposed work – was equivalent to the acceptance of the work with patients on the same basis. For the CSM staff, to grasp this dimension of "dutiful fulfillment" meant to grasp the meaning of the work we were doing together as well as the nature of the problems they were encountering with their own patients.

But the demand can also develop along different lines. There was, for example, a woman business manager who felt she was unable to cope with the ingravescent problems of her adolescent daughter. In this case the clinical psychologist was consulted by the woman herself, i.e. by the person who was interested in the development of a thought about her own emotions. She asked for advice and orientation to "treat" the girl and her behavioural problems, consisting, in the mothers' words, of: excessive "closure", fear of approaching boys, "disorientation" at school continuous reproaches directed toward her mother for having separated from her father, pretension to find in her mother a fellow to compensate for the careful avoidance of schoolmates and for the complete absence of any friendship; attitudes which were suggestive of depression, sovereign melancholy, existential sadness. The woman asked for "advice": she expected to discuss with the psychologist about the problems of her daughter and to work out together, almost as if they were a couple of parents, the best strategies to help the girl out. The demand seemed to arise from a failure of the mother-daughter fusional collusion, and what the psychologist could actually do was to help the person with whom he had a relationship (the concerned mother) to develop a "thought about emotions": the emotions that made her await for an advice from a psychologist, as well as the emotions characterizing her relationship with her daughter. Examples might be multiplied, but it should be sufficiently clear by now that, in our view, the development of a thought about the emotions which are evoked by the relationship is the one and only path a clinical psychologist can take. The emotions which can be primarily "thought about" are those originating from the motives which organize emotionally the relationship between the person who makes the demand and the person to whom it is addressed.

Where?

The development of a thought about emotions is closely interrelated with the context in which the psychologist is asked for his services. Therefore, clinical psychological intervention is definitely oriented toward promoting competence within the specific work context of who makes the demand. It is essential to get to know in depth the cultural characteristics of the organizational or institutional context in which the intervention is going to be carried out. For this reason, a line has to be drawn between "clinical cases" and "critical events".

Supervision is most commonly requested, by mental health organizations, for "difficult" clinical cases: this kind of work is based on the analysis of the psychodynamics of the case at issue, and it is aimed at finding the best suited strategies to manage it; the dynamics characterizing the functioning of the service – which are evoked by, but not limited to, that one specific case - are instead left out. Much differently, "critical event" indicates a relational

situation which, although being born from a specific clinical case, is managed by comprehensively taking into account the emotional involvement of the several organizational components participating in the overall clinical dynamics. The clinical psychological approach to a critical event is not limited to the analysis of the clinical case and of its intrapsychic, cognitive and relational psychopathological components: it consists instead of the analysis of the whole relational dynamic, involving the operators and the patients as well as the patients' families, the management, and the conflicts which are inherent in the context.

Let us look at some examples.
During one of the already mentioned interventions of organizational counseling, a group of CSM operators discussed at length about a "severe" patient and the rough time she was continuously giving to the service. In their words, she had the following problems: she lived with her mother; both of them had ventured into marriage, although at different times, but both seemed to have put husband to flight after a short period of cohabitation. Periodically, the patient decided that she was to be admitted to the SPDC of the service; systematically, after a short period of time, she *expected* that she was to be transferred to a Therapeutic Community and, once she was there, she *expected*, among other things, to have free days to spend with her mother (those days were often spent by the two of them inside the small parks next to the Community); as the last step of such a reiterated cycle, the patient claimed that she was to be discharged to do psychotherapy at the CSM, where she peremptorily *expected* to be prescribed the "medications" she decided - among which a special place was reserved to the "Kinder Surprise" (chocolate eggs containing a small toy), for which she was greedy. The operators were bewildered by her behaviours, and they also expressed a marked aggressiveness toward the changeability of a person whose objectives totally escaped them. We looked together at her "acting out" and we realized that the common trait of all her behaviours was to be found in her ability to anticipate the services' decisions, "making them do" the actions which usually services "make patients do" In other words, the woman seemed to exert a "personal" and "capricious" power over the services, so as not to passively undergo the power of the health system. She went so far as to make her psychiatrist ape medication prescribing by actually prescribing her sweets. The operators' aggressive irritation could then be easily understood: the woman systematically managed to "turn upside down" the traditional power relationship between operators and patients by appropriately using her "madness", and that led to the failure of the usual therapist-patient collusion, based as it is on the passive dependence of the latter on the former. Such a failure of collusion evoked in the operators "unthought" emotions of refusal not only of the patient, who was compulsively talked about, but also of the clinical psychologists - i.e. of a work of reflection on organizational functioning which, they said, is bound to be useless when severe and "deconstructing" patients like that actually preclude any possibility of predicting or planning. It was thanks to the thought about the emotions evoked by the patient that it became possible to grasp the meaning of the emotions experienced by the operators within our intervention. The "thought about emotions" was made possible by the competence to contextualize relationships or, in other words, to highlight that the relationship with the "severe" patient, as it was described, actually implied the upsetting of the usual "balance of power" between health workers and patients. It is interesting to note that the thought about the emotions evoked by the patient, as well as the simultaneous analysis of the traditional health system "culture" she tried to upset to her own "advantage", evoked in the operators a sense of relief and irony. A traditional supervision would have focused their attention on the patient's pathology; the work we carried out on the critical case enabled instead a process of thought about the emotions evoked by the relationship between the patient and the service/context as a whole.

A young university student came to me at the pressing invitation of his mother, who was worried for the failure in his engineering studies, used as she was to see him standing out among his high school peers. He came – he said – just to please his mother: in his opinion, things were not so bad. In this case, the context was represented by the student-mother-

psychologist triangle. The patient was passively pleasing his mother, as her he couldn't oppose, but rejected and foiled any possible work with me, which to his eyes was merely a useless extension of his mother's concerns. Quite on the contrary, he was neither worried nor interested in the development of a demand for help. The context actually organized itself according to the usual relational model of the patient: a relationship with female figures which was characterized by passivity, and a relationship with male figures which was characterized by defiance. High school, with its daily attendance and its systematic control over absences (roll call) and preparation (oral and written tests), was to him the comfortable and regular maternal function; university, with its freedom, its lack of controls, its crowds of students, its regulations all based on autonomy and personal initiative, hinted instead at a sort of paternal function, with which he was called to identify. Thus, the "triangular" context properly represented the underlying emotions which were acted out by the student within his forced and passive relationship with the psychologist. And this was exactly the dynamic within which the psychologist could work, taking into account that the patient – in spite of his defiant attitude, signified by his unconcerned passivity - wanted to know, with a part of himself, the reason why he had accepted to come.

To take context into consideration and to analyze its relational dynamics means to understand the relational emotional symbolizations on which the failure of collusion was based and, accordingly, the emotional dynamics which are reproduced in the relationship between who makes the demand and the psychologist.

How?

Interpretation is the clinical psychological tool *par excellence* But to interpret means to facilitate a thought about the emotions which are evoked by the relationship and experienced, by who makes the demand, within the demand relationship itself and its own contextual dynamics. Interpreting, in fact, is not explaining. Emotions are necessarily conveyed along with any interpretation, since the latter is necessarily put forward within a relationship.

To a group of operators irritated by a "manipulative" patient who "makes them do what she wants", the psychologist may well tell: "hey guys, you fell right into her trap!" This may help them to understand the emotional process in which they are entangled together with the patient, but at the same time it may suggest that they are scarcely able to understand. More than as irony, it would quite possibly be perceived as sarcasm, as it would somehow imply sort of a derision, and sarcasm inevitably triggers defense mechanisms aimed at denying what is being proposed. As an alternative, the psychologist may draw the operators' attention to the reassuring sense provided to the patient by her anticipation of the services' decisions. And, also, to their affection toward the patient – to that one affection on which their indulgence of her requests is based. Last but not least, to the deep bond between the woman and the mental health services as a whole, from which she can't separate and within which, if you come to think about it, she is planning all her life. In this way, along with interpretation, the psychologist conveys his sympathy for the group of operators, for their hard work with difficult and complex patients, for their dedication, and for their interest in understanding, together with him, what is emotionally happening.
According to Strachey, mutative interpretation is able to replace – within the patient's internal world - a punitive and severe superego[3] with a more supportive and benign one. Such a replacement is not a mechanical one, and it depends to a great extent on the attitude of the clinical psychologist toward the persons or groups he's working with. This is a most relevant point. In our view, an ironic attitude is a key factor to this kind of interpretive strategy. To be ironic means, for the psychologist, not to take himself too seriously; it means

[3] Strachey refers to the second Freudian topic. In our view, we refer to the first Freudian topic and to the unconscious mode of being of the mind as "the true psychic reality".

to offer a meaning for what is happening within the relationship with the client, but also to be able to accept the possible refusal of it, and to wait for the right time to try again, since that given meaning, in that given moment, couldn't apparently be recognized. Each psychologist develops his own personal style as to this, but what is important is the awareness that an interpretation can only make sense if it is offered as a facilitator of a thought about the emotions which characterize the contextual relationships of who makes the demand. This means that the psychologist has to accept and to get to know in depth the context in which his client lives or works; and that he has to continuously work out and give sense to the emotions which he feels are evoked in him by the relationship with his client.

Some exercises can also help to reflect on collusive dynamics, provided that it is made clear that the expressed behaviours are not to be viewed as something that should adhere to a model or should be corrected. The prisoner's dilemma, which is all too often used by psychologists to condemn competitive and praise cooperative bahaviour, might serve here as a good example. Let us look at an exercise, called "TAT in Aquarium" (where TAT stands for Thematic Apperception Test), which we carried out with some CSM operators at the end of a series of most interesting and complex sessions aimed at the development of a thought about their work. The twenty operators were asked to split in two groups, and each group was given a different picture. Each operator was invited to draw inspiration from the picture to tell a story and, in order to get him deeply involved in it, he was encouraged to write a story as emotionally interesting as possible to express his competence to explore the emotions felt by the characters' and to dramatize the relationships among them. One of the two groups was then placed in the middle of the room and asked to create a "group story" based on the same picture that had been used for individual stories. The second group was invited to observe the relational dynamics expressed by the first group, in order to tell which relational processes seemed to facilitate and which to hamper the achievement of the aim.

While working at the "group story", the first group dwelt lengthily on the individual stories, and only toward the end of the assigned time it began to write down the collective one. As for the final result, both groups agreed that the "group story" had resulted in some emotional impoverishment when compared to the richness of the individual ones. When it came to the second group, most of the time was again "spent" on the individual stories, and it was again only toward the end that they resolved to have the "group story" actually represented by the one individual story they had liked better - they thought that better than the others it represented the group itself. The traditional "didascalic" purpose of this exercise is to observe the inherent difficulty in giving up one's personal positions (narcissistically solicited by the creation of one's own story) in order to join a group in a common productive effort (the group story). From this perspective, the above results seemed to confirm – in the first as well as in the second group - the strength of individual narcissism and the difficulty of sharing a common aim or effort. However, such narcissistic dynamics were far from being apparent during the reading of the individual stories: on the contrary, each and every operator showed a profound and intense participation in it. One of the reasons for this lied in the collusive, hence "group", significance of the individual stories: each operator had symbolized in his own story a facet of the collusive dynamics belonging to the group and to the experience as a whole. Thus, the compositions were not single "individual" stories but rather many different group stories, which had all been inspired by the intense and shared participation of all the operators in the various phases of the intervention. The understanding of the collusive meaning and of the symbolic dynamics of the individual stories, which had been able to recapitulate the vicissitudes of the experience and of the psychologists-operators relationship, turned out to be a key step: the exercise actually represented the height of a process of emotioned thought about the service's functioning, and the interpretation of the collusive meaning of the stories was able to render the productive dynamics of the experience in all their depth.

Who?

Last but not least, a role within the clinical psychological intervention has to be assigned to the psychologist himself. The psychologist's credibility is at issue here, as well as the emotional symbolization according to which the psychologist is experienced by the person who makes the demand and takes part in the relationship within which a thought about emotions is promoted. The emotions which can be primarily "thought about" are those belonging to the demand relationship itself, i.e. those which are evoked by the figure of the psychologist, by his function, by the way he presents himself, and by the way he works within the relationship. The figure of the psychologist and his emotional representation are the first emotional stimuli which can be used to foster the development of thought. These emotional dynamics, which in the past we have referred to as "institutional transference", consist of a process of emotional symbolization, of the psychologist as well as of the demand relationship, that is produced by both the symbolic reproduction of contextual relationships and the way the psychologist-patient relationship came to be established. In other words, institutional transference is made up by the patient's as well as by the psychologist's contextual symbolizations.

Let us think, for example, of the simple, albeit not easy, case of the therapeutic relationship between a psychologist and his first and/or only patient. The psychologist's ways and attitudes, in such a circumstance, are easily dominated by a "fear to lose the patient". Such a difficult relational arrangement is often put to an end by the very event the psychologist feared, due to the well known pressure exerted by self-fulfilling prophecies.

Or let us think of the underemployment conditions in which psychologists frequently find themselves within the most varied work contexts: the communities for people with severe psychiatric disorders, where psychologists are actually asked to assist patients with their daily routine of personal hygiene, to secure custody in order to prevent them from escaping, and to do the night shifts; the psychologists working as AEC (*Assistente Educativo Culturale*, i.e. Educational Cultural Assistants), who are merely asked to accompany disabled pupils and students through their school and after-school daily activities. Such roles, when played by psychologists, might well grow into interesting professional functions; but most often psychologists do the work passively, accompanied as they are by the rage and the regret that their professionalism is not being acknowledged.

The relevance of the issue of the psychologist's role becomes especially apparent when it comes to the Italian situation, which more than others is currently characterized by widespread job insecurity, underemployment, and unemployment. However, it has to be said that our psychologists are often trained only approximately, and for this the Italian university faculties must be held responsible. In describing his first professional experiences, a young psychologist said that, while working, he had his mind befuddled by two major emotional problems: a tendency to imitation, and rage. The two factors were closely interrelated: his lack of experience led him to imitate what he had seen his university professors do during the lessons and the practical sessions: so, he would utter some of the fascinating words he had heard spoken, he would apply some of the exercises he had done with them. However, such "repetitions" failed to really reproduce the experiences he had lived during his training, and he ended up overwhelmed by a sense of impotent rage and by a profound disesteem of himself for only being capable of those useless imitations. The received training should turn instead into a competence that has to be based on one's own personal style, on initiative that can only stem from the understanding of the dynamics which got to inform the professional relationship, and on the psychological role that can be progressively acquired thanks to competence itself.
If professional role is primarily defined by the acquired competence, the context and the historical and cultural period also play a part, and psychologists need to have a clear understanding of the role that is assigned to their profession by the specific context they finds themselves in. Psychological professional competence can by no means be taken as something *ahistorical*: on the contrary, it is essential to put it in the framework of the current

culture and of the prevalent economic, social and political conditions. The sense of historicity we are referring to is not the one that can be acquired just by studying the history of psychology, which - mainly consisting of the painstaking reconstruction of a series of obsolete experiences – can even contribute, somewhat paradoxically, to draw our attention away from the current historical context. A real cultural awareness can only be achieved by delving more and more into psychological knowledge, and by putting it in the framework of a broader analysis of the economic, political, social, and artistic world surrounding the events and problems of the social groups within which we work and to which we belong. By the way, this is the perspective from which the important limitations of psychological training in our country can be best appreciated.

PART II – THE STAGES OF CLINICAL PSYCHOLOGICAL TRAINING

Introduction

As we have seen, the defining purpose of clinical psychological and psychotherapeutic intervention is the facilitation of a thought about the emotions which are evoked by the relationship between who makes the demand and the professional to whom it is addressed. To foster a psychological competence which, in its complex professional articulation, may be specifically suited to meet this objective, is precisely the aim of the SPS School of Specialization "Psychoanalytic Psychotherapy: Clinical Psychological Intervention and Analysis of Demand"[4].

The major points of our training course can be summarized as follows:

1 – To get to know one's own emotions within the clinical relationship

2 – To get to know, in connection with one's own emotions, the emotions of the "emotioned other" within the clinical relationship

3 – To interpret, i.e. to propose an emotioned thought about the emotions which belong to the clinical relationship

4 – To work out the frustration which is inherent in clinical work

Let us look more closely at these points, which we consider of paramount importance for the development of a clinical competence as we have defined it above.

To get to know one's own emotions within the clinical relationship

Clinical training starts right from the trainees' emotions: they have to learn to know them, if they want to get to know what is happening within the clinical relationship. The relationship is the "place" where the two emotional knowledges, that of oneself and that of the "other", take on a unified, integrated function. We're not speaking of getting to know one's emotions "in general", or within the relationships organizing one's "personal training", like those underlying the experience of one's own personal or training psychoanalytic experience.

At SPS School, we have discussed at length about the convenience of *prescribing* to the trainees a personal psychoanalytic experience as a prerequisite to admittance to the

[4] The school was founded in 2004 by SPS (Psychosociology Centre of Rome), the school Director is professor Renzo Carli and the Scientific and Learning Committee is composed by the Director, and Paola Cavalieri, Anna Di Ninni, Rosa Maria Paniccia and Pietro Stampa.

School's clinical training. The conclusion we have come to is that such a requirement is *not* convenient, and this for the following reasons:
a - the mandatory psychoanalytic experience patently represents a paradoxical injunction; one can't possibly have any psychoanalytic experience if his objective is other than to participate emotionally in the analytical relationship, in order to work out his recognized problems, and as a consequence of an autonomous decision. Accepting to do a psychoanalysis in order to be admitted to a training course means nothing less than perverting the analytic experience or, in other words, turning it into something else. It is plain to see that this can't be the starting point of a training process.
b - the experience of a personal psychoanalytic treatment can only be useful if it is motivated by personal problems producing a demand. However, such a usefulness does not assure by any means that a clinical competence is acquired to practice and carry out whatever kind of psychoanalytic intervention. In fact, personal treatment can help to work out one's own emotional dynamics, within the clinical relationship and insofar as the problem which has motivated the analysis is concerned, but it does not train to assume the professional role of psychologist, nor does it help to acquire a competence to work clinically within the whole range of the possible social and organizational contexts. As for the professional role, most often the problem gets to be solved just by identifying with one's analyst, and by remaining within the boundaries of the binomial imitation-rage dynamics we have already hinted at. Moreover, relying on one's personal analysis to acquire a competence to carry out psychological interventions in different social context has as its typical outcome the accomplishment of conformism.
c - training is a clinical experience *per se*, within which the trainees experience relationships which can well serve to bring to light the individual emotions as well as the emotions belonging to the collusive process underlying training itself. The training process, in its various articulations, is nearer to the social and cultural contexts of intervention than the "dual" psychoanalytic relationship is. In this sense, the knowledge of one's own emotions can be acquired within the training process itself, provided that the latter is organized so as to allow it. Training entails the experience of multiple relationships: the one between trainers and trainees, obviously; but also the one between the trainees, in its various articulations (between males and females; between trainees of different age, cultural background, or motivation; between the individual trainees and the training group as a whole), the relationship between the school as an institution and the trainees, the one between the school and the cultural context in which it operates, the one between the trainees, the school and the internship organizations. All these relationships can allow the trainees to go in depth into the "emotioned" process of getting to know their own emotions.

It is particularly, though not only, during the first year of our course that we run a series of activities which are specifically aimed at the achievement of such a knowledge; in fact, a consistent part of our teaching efforts is aimed at *monitoring the learning process* and at *monitoring the internship experience* We work in small groups, and the analysis of the relational process and of the emotions which are evoked (in the single trainees as well as in the group as a whole) from the participation in the groups themselves is the main purpose of our exploration and discussion of the collusive dynamics.

To get to know, in connection with one's own emotions, the emotions of the "emotioned other" within the clinical relationship

This is a key step of the process aimed at training the students to use the psychoanalytic relationship which belongs to the intervention. To access our own emotions a direct path can be taken, a somehow intuitive approach that mainly relies on primitive emotional categories such as friend-enemy, inside-outside, high-low, before-behind, and within which emotions are related to such motivational themes as the need for belonging, the acquisition of power within one's group of belonging, and the wish to produce something according to standards of excellence. To get to know the other's emotions within the clinical relationship

is a more difficult and circuitous task, and a more complex categorical framework is needed to suitably organize what can be intuitively grasped. The other can't be known as an independent entity which is separate from us; instead, we can only get to know another who is being emotioned within and by his relationship with us. The internship experiences acquire in this sense a prominent role within our training course. A thorough reflection on them allows us to look at the way the trainees enter into relationship with the other outside the school's boundaries: be this "other" the organization within which the internship is carried out, the internal supervisor of the experience, the patient to whom the trainee makes the initial interviews or the analysis of demand or the therapeutic sessions, a family member of an SPDC inpatient, or a psychiatrist/nurse/educator/social worker with whom the trainee cooperates in the management of a clinical case or whose work the trainee is called to shadow. Once again, attention has to be drawn not to the clinical case but to the critical event as a whole; and such a critical event can only have a training value if it is possible to get to know in depth the emotions which characterize the different relationships experienced by the trainee, within his internship as well as within the school.
Most importantly, the process of getting to know the other emotionally must not be founded on a preconceived knowledge base (such as the various psychopathological classifications), nor on stereotypical dimensions. Getting to know the other's emotions is something in between what one understands of his own emotional dynamics and what he can suggest to the other so as to make the other get to know something about himself. Such a process perilously hangs in the balance between the defenses which are triggered to avoid recognition and the pointlessness of providing the other with sterotyped definitions which he won't be able to put to any use. To get to know the emotions means to communicate, as it cannot but involve the conveyance, to oneself or to the other, of the knowledge itself. If it is not communicated, emotional knowledge inevitably turns into acted-out reactions and can't serve any clinical psychological purpose.

The emotional knowledge of the other has to be experienced rather than studied. It is only by experiencing emotional relationships that one can slowly and laboriously begin to construct the categories which he is going to use to get to know the other's emotions. These categories cannot initially be but idiosyncratic, and they take some time to become comparable and discussable among trainees or colleagues. In this sense, we consider of major importance that knowledge be converted into report[5]. To get to know the other by means of preconceived psychopathological categories is just diagnosing, and diagnosing can hardly be put to any use, given its most limited sense in clinical psychology. To get to know the other by means of "emotioned" categories, which are drawn from the knowledge of one's own emotions and of the emotions belonging to the relationship, produces instead a knowledge that can be reported - to oneself and to the other, as well as to the whole scientific community. In other words, we get to know the other's emotions by means of our own emotions, of those emotions which we feel are evoked and solicited by our relationship with the emotioned other. Thus, to get to know our own emotions - our own emotions within the clinical relationship - represents a preliminary step to get to know the other's emotions.
The latter issue is of paramount importance. We can get to know our emotions within our family relationships, or within the relationship of our personal analysis, which so often reproduces our family dynamics within the transference process, but things change dramatically when it comes to getting to know the emotions of *the other we have clinically taken in charge* The assumption of clinical responsibilities markedly modifies the relational as well as the getting-to-know process, of the trainee and of the experienced professional alike. Within the clinical relationship "the other is speaking of you" while trying to get to know himself. Such a "speaking of you" emotionally engages the psychologist in an intense and specific manner to the clinical psychological profession: the professional's defining competence is precisely to work out and give back usefully to the other the emotions which he has got to know by means of his own emotional involvement in the clinical relationship. Such an involvement continuously calls into question the personal as well as the

professional identity of the psychologist, his self-confidence, his image, his reality check, and his competence to think about the emotions which he feels are solicited in himself by the other's emotions. The defenses which are triggered against this process are most often massive and drastic: to pigeonhole the others into psychopathological categories may well help, for example, to bear the emotional pressure ("yes, now I know the reason why he always evokes in me this overwhelming rage: he's a paranoid personality!" - here again, the clinical case has replaced the critical event…). The emotional acting out may become quite uncontrollable, and the psychologist may come to the point of reproaching the other, of making fun of him or denigrating him, or he may put between himself and the other a sort of screen of "non affection" which may all too easily verge on cynicism. Other defenses may consist of self-related emotional reactions, ranging from a depressive response to the proposal, to oneself as well as to the other, of a grandiose and omnipotent self. These defenses are often explained as the outcome of an incomplete working out of one's emotions within one's own analytical experience, but they are actually used also by the most thoroughly and fully analyzed psychologists; this is because they don't really come from an incomplete analysis of the self, but rather from a lack of adequate training in the process of getting to know the other's emotions *within the clinical relationship* In classical psychoanalytic training, the first clinical cases which are taken in charge by the trainee are mandatorily supervised, and this is undoubtedly a useful experience. However, in our view, supervision should concern not only the clinical case at issue, but also the whole set of emotional dynamics which we have called a "critical event" In fact, to limit supervision to the specific clinical case hardly allows to understand those clinical situations which have to do not with the "dual" relationship of a psychoanalytic treatment but with the whole set of relationships characterizing the clinical psychological intervention, be the latter carried out within health or educational organizations, within institutions of whatever kind, or even within the supposedly "dual" setting of a psychoanalytic treatment. This is the reason why we are more inclined to monitor critical events than to supervise clinical cases.

The second year of our four-year course is specifically dedicated to the process of getting to know the other's emotions within the clinical relationship. To this aim, we continue to use the monitoring of the learning process and the monitoring of the internship experience, but an important and specific contribution is also made by a few new subject matters, which are teached by delivering what we call "emotioned lessons"[6].

To interpret

A most interesting issue concerns the way an "emotioned thought about the emotions which are experienced within the clinical relationships" should be conveyed to the other with the purpose of fostering in him a thought about his own emotions.
Let us start by looking at the definition of Interpretation that was provided by Laplanche and Pontalis[7]:

"A – Procedure which, by means of analytic investigation, brings out the latent meaning in what the subject says and does. Interpretation reveals the modes of defensive conflict and its ultimate aim is to identify the wish that is expressed by every product of the unconscious.

B – In the context of the treatment, the interpretation is what is conveyed to the subject in order to make him reach this latent meaning, according to rules dictated by the way the treatment is being run and the way it is evolving." (p. 238-239 1° vol.)

The key word, here, is "explain", which comes from the Latin *explanationem*, explanare "to make plain or clear, explain", literally meaning "make level, flatten". From ex- "out" and planus "flat". It can be taken to mean "to show", "to display", "to bring to light" or "to make

[6] See the book written by Carli, Grasso and Paniccia.
[7] Laplanche J., Pontalis J.-B. (1967), Vocabulaire de la Psychanalyse, PUF, Paris.

clear". According to the above authors, to interpret means to get to the unconscious wish which might have been disguised by a defensive conflict or, in other words, to bring out or reveal the unconscious wish so that it can be "made clear" to the patient. When interpretation is given to the patient, according to the specific methods and rules of the psychoanalytic treatment, he is allowed to get to know the latent meaning of his own words and behaviours – a latent meaning which was already there but which could not get to be known as it was not "plain, clear". What strikes us as ironic is that, if interpretation means that something is finally "brought to light" and "made clear" to the patient, interpretation seems to leave little room for shadows and doubts, and hence for interpretation itself. In our view, developing a thought about the emotions which are evoked by the relationship is quite different from bringing out a latent wish. If the latter work has a preconceived and precise objective, the former one offers instead a chance to turn emotional experiences into words which can be used to give a sense to emotions themselves. As we have already seen, the clinical relationship originates from a demand, and the demand stems in turn from a problem which is experienced by the patient within his habitual contexts. In other words, the problem turns into the emotions which are experienced within the clinical relationship between who makes the demand and the psychologist. It's up to the latter to put forward a thought, about the relational emotions, which may be able to give a sense to the emotions themselves. If repeated within the clinical relationship, the process of giving a sense to emotions can help to give a sense to the problem from which the demand was engendered. The succession of the interventions of the psychologist, repeatedly aimed at giving a sense to the emotions which are experienced by the psychologist himself and by the person/organization who/which made the demand within the relationship with him, allow the sense of the original problem to be understood.

What makes interpreting so difficult is the epistemological discrepancy between the emotional experience as it is lived and the thought about the emotions. If thought is expressed by categorical language, emotions have nothing to do with it. The relationship between the emotions and the thought about the emotions resembles the relationship between the lived experience of a dream and the narration of that dream to a psychologist. When "narrated", a dream undergoes a profound symbolic transformation: the lived experience has to become a narration of the experience, so as to allow an idiosyncratic experience to turn into a message that can be communicated: a "lived" dream is a "private" event, belonging to the dreamer only, whereas a "narrated" dream is a "public" event, inasmuch as it establishes a relationship between the narrator and the recipient of the narration. Language is a most imprecise tool when it comes to turn emotions into narrations. Moreover, when it is used by the psychologist to talk about the emotions which are lived within the relationship, language reflects the categories which are used to analyze emotions by the psychologist himself. It is only when the psychologist's communication turns into the patient's sense-giving effort that the process can really start to confer a meaning to the problem from which the demand originated. The latter task can only be carried out by the person who made the demand, with the help of the psychologist to be sure, but also provided that the psychologist does not take on the function of thinking about the emotions in place of his patient. Let us try to clarify this point by giving the example of what a trainee of our SPS School reported during her internship in a Therapeutic Community for severe psychiatric patients. In a nutshell, an event regarding her relationship with a patient that we will call Antonio evoked in her emotions which she was not able to think, let alone to interpret. Here is the excerpt:

My first aim within the internship experience can be represented by what happened one day with an inpatient called Antonio. We were inside the smoking area, and we were sitting at a table together with other inpatiens but with no other operator; I'm pointing this out because I feel it's worth further investigation and I'm still thinking about it: when another operator will join us, Antonio will resume immediately his down-looking, self-absorbed stare and, if talked to, he will answer again laconically and in monosyllables. Antonio's talk followed the one from another inpatient, Corrado, who often showed off to me his extreme experiences: that time he was telling me of the great amounts of cocaine he had sniffed, of the joints and alcohol he had consumed since his early adolescence, and

of the many times he had felt really bad as a consequence. Antonio interrupted Corrado and threw out: “And what about me? You don’t know that for a week I’ve been a member of a Camorra gang!” After that, he started narrating the things he had seen done and the things he had undergone: he told me of his own initiation ritual, of the threatening people belonging to the gang, of how much they “destroyed” themselves with drugs and alcohol, of all the things he had felt compelled to do, some of which were related to distorted religious symbols, as the cross, which was the symbol of the gang, and of how they had ordered him to engrave it on his own body; then he stood up and said he wanted me to see the cross he still had, and he bared his arm, adding that he had used small scissors to do it. What I saw was a real bad scar, and a badly healed one; I saw the pain. What had started as an attempt to stand out had now turned to be something else too; in fact, he was telling me all those things with a grin on his face, which I thought had the purpose of seeing to what extent I would have been frightened; I felt he was teasing me to look at my reaction to those intense and literally scaring tales; his conversation seemed to have turned into sort of a defiant challenge as to who would have been frightened more. I also felt that my reactions had become especially relevant, and at the same time I perceived sort of a trembling, and a desire not to know, not to see, to escape from such an experience. I asked myself if those emotions concerned myself only; *thus, I asked Antonio the reason why he had thought of telling me that story at that very moment*; Antonio apologized, and asked me if he had spoken too much, to the point of boring me; I replied that I was not bored, and that I was interested instead in understanding, together with him, how his Camorra experience had come to his mind; this might have helped us, I added, to understand the way he felt in that moment. After having thought for a while, he said he believed it had occurred to him because he was afraid; he said that the following day he would go back home for two days, and that the one who had been his best friend, and who had brought him into the gang, had promised, together with the rest of it, he would kill him for having left. At that moment, I felt so bad for him, and I wished I could reassure him, but how could I? And to what? Then I remained silent, and I tried to find out how to carry on the conversation in some useful way; at that very moment, the already mentioned operator entered the room, and her presence stopped it all. Antonio, who had looked me intensely in the eyes for all the time we had talked, hunched his shoulders and lowered his head, to the point that I could hardly see his eyes, and his eyes themselves were again sort of “screened”, and immersed, I believed, in some parallel reality. The operator had helped me out of the difficult task of continuing to bear those intense emotions, and to try and find a way to use them in order to develop a thought that might have been somehow useful to Antonio.

The trainee had actually colluded with Antonio’s attempt to frighten her, and she had failed to think about the emotions that the inpatient wanted to evoke in her. The problem of Antonio lied in his rivalry with Corrado, as they shared the desire to arouse the woman-trainee’s interest by displaying a manly courage which they equated to a death-defying, self-destructive attitude. The trainee had been involved into the “frightening events” to the point of being unable to find the words and give a sense to the emotions characterizing her relationship with Antonio and Corrado. There were no other operators around which might have inhibited the exhibitionism of the two inpatients. The trainee apparently felt “attracted” by the relatonship with Antonio and, by asking him the reason why he was telling her those things at that very moment, she seemed to look for a confirmation of her own fear/desire of being frightened/seduced by the story. Antonio’s sarcasm was quite apparent as he said he was afraid of having *bored* a listener who actually was in considerable difficulty due to the uncontrollable emotions which the story was evoking in her. The trainee knew that she was expected to help Antonio to think about the emotions which were flowing through them, but she failed in the intent as she was unable to grasp the meaning of her own emotions: she couldn’t even think about them, because she was too involved in the collusion. When the second operator entered the room, Antonio withdrew back into himself because a sense had not been given to his emotions and to the emotions of the trainee. He had tried to establish a seductive relationships with her, but in his fantasy he could only gain her attention by exhibiting destructiveness and connections with cruel and dangerous people. At the time, Roberto Saviano’s “Gomorrah” had been published, and the author had been threatened with death by the Camorra; and, by the way, isn’t Gomorrah the city near the Dead Sea which, according to the Bible, was destroyed by God, together with Sodom, for the corruption, the impiety and the moral decay of its inhabitants? Antonio seemed to be frightened as much as the trainee; he was frightened by his own inner world, by his own emotions of impotence - by those emotions which led him to fantasize about close ties and

pacts with most powerful and cruel criminal organizations (close ties and pacts which were to be sealed with the indelible mark of the blood). He had tried to seduce the trainee, but that was actually his way of asking for help, of putting his problem forward. And his problem lied in a withdrawn attitude which was aimed at keeping him away from the fantasy of inducing fear into the others in order to exorcise his own fear. He could somewhat escape from his own retirement by frightening a woman, provided that the woman did not get frightened and helped him to think about his emotions. Our trainee was instead too involved in the collusive dynamics: she did get frightened and she could not find the words to give a sense to the relationship between herself and Antonio.

Interpretation is thus aimed at communicating to the other a thought about the emotions which flow from who made the demand to the psychologist and viceversa, so that these emotions acquire a meaning consistent with the problem motivating the demand and organizing emotionally the clinical relationship. The thought which gives a sense to the emotions belonging to the clinical relationships also gives a sense to the problem which is symbolically represented within the clinical relationship. To interpet means, for the psychologist, to access his own emotions within the clinical relationship in order to get to understand the meaning of the ralationship itself; it also means to have the categorical competence to turn the thought emotions into words which are able to facilitate in the other a thought about his own emotions. This is what we have called “emotioned thought” If thought and communication lack this emotioned connotation, it is not possible to convey to the other a meaning which can really help him to think about the emotions he lives in his relationship with the clinical psychologist. As we have already pointed out, explanation is the opposite of interpretation. It is really important to understand that interpretation concerns the critical event of the relationship between the person who makes the demand and the person to whom it is addressed, whereas explanation concerns the clinical case, i.e. the problem of the other as it emerges from the unconscious wish that has to be brought out. Once again, it can be noted how far the process of giving a sense to the *relatonship* is from the process of *diagnosing*.

The third year of our course is mainly devoted to interpretative intervention, and to the ways by which the other, be it a single individual or an organization with its various components, can be helped to give a sense to the emotions characterizing its demand relationship. Such a yearly differentiation might appear too schematic: indeed, it proves most difficult to separate the getting to know one’s emotions from the getting to know the other’s emotions within the relationship and from the getting to know how to work within the relationship in order to give a sense to the problem motivating the demand. However, as we have seen, the above three areas of clinical competence - and most of all their respective internship experiences - are somehow preparatory to one another. By the way, it might be interesting to note that the trainee of the above example was in her second year.

To work out the frustration which is inherent in clinical work

There are several reasons to view clinical psychological work as an especially frustrating one. First of all, the outcome of clinical psychological work is not easy to be seen. The cook invents a special fish dish, the surgeon excises a brain tumor, the mechanic fixes the brakes, the economist devises a government monetary strategy that is bound to save the country from the financial crisis, the carpenter makes a wordrobe or a window, the architect renovates an apartment. What about the psychologist? The product of a psychoanalytically oriented psychotherapy or intervention within a health organization cannot be “seen” so clearly and readily; results take some time to become apparent, and more often than not the psychologists cannot appreciate any “product” while they’re still in the process of working at it. As we have said, though, the outcome of clinical psychological work is mainly “methodological”, as it consists of the fostering of a competence to think about emotions,

and as such it is not something that can be “seen”. The tolerance of ambiguity appears therefore to be a key factor to psychological competence.

A second cause of frustration lies in the contingent and uncertain nature of the relationship between the psychologist and the client. If the objective of clinical psychological intervention is the facilitation of a thought about the emotions which are experienced within the clinical relationship, how many people will be interested in it? Young clinical psychologists know this all too well, as they most frequently experience how hard it can be to find a client for their work, and they may spend even years awaiting for someone who resolves to ask them for their professional services. Youth unemployment, which is a common feature to all work areas, is heavily supplemented, in the field of psychology, with the frustration coming from the impotence to put forward a sense for one’s own competence, or from the impotence which is associated to the “empty relationship” between the problems as they are experienced by single individuals and social systems and the clinical psychological competence.
The poor definition of training guidelines also makes an important contribution: it seems that clinical psychological training is bound to never end. There's always something more to learn, to delve more deeply into, to work out better, in the psychological field but also in the economic, sociological, historical and broadly cultural field. In fact, nowadays, beyond his technical expertise, the clinician has more often than not to propose himself also as a highly cultured man, and to show a “preparation” that university studies and books alone just can’t provide.

A fourth factor of frustration is the marked tendency to reversibility systematically affecting the advancements which have been so slowly and laboriously achieved by the clinical relationship. For example, we have worked hard within an organization, overcoming many obstacles, in order to obtain a slow but perceptible cultural change, but then they have a change at the top, and it deeply modifies the cultural adjustment we had come to. Or, we have most laboriously worked together with a patient who now seems to understand important facets of the process, but then some external critical event occurs (such as the death of a beloved one, or a problem at work or with friends) and poses new challenges to the clinical relationship.
The list might well go on, as we might speak, as a further example, of the deep frustration and of the profound crisis of self-esteem and professional identity which the psychologist has to face when a patient, who had asked some time before for his help, decides - unilaterally and rather incomprehensibly - to end the clinical relationship.
In short, the clinical psychological profession is a difficult one. It requires a high level of self-confidence and of tolerance to frustration, and it is facilitated to a great extent by places and relationships of belonging which may at least partially compensate for the feelings of loneliness and of being abandoned which are so easily lived by the professional. The importance of working on this subject, so as to come to a better understanding of the several experiences of frustration which are interspersed throughout the professional life, cannot be underestimated. To young psychologists, who are been trained to clinical psychology or to psychotherapy, the example of senior and well-established colleagues may give the illusion that our profession is made up of social power and gratification, and of an uncritical dependence of the client from the prestigious professional. This *is* an illusion. The authors of the reports which can be read in books and scientific papers are basically inclined to present their professional successes rather than their failures. As for as psychotherapy is concerned, for example, they rarely report or theoretically analyze, with or without specific training purposes, the cases in which the patient decides to end the treatment.
Internships are the key training experiences from this perspective as well, as they offer a unique opportunity to explore the frustrating aspects of the clinical profession: the young psychologists can be helped to grasp the relevance that frustration can have for their own training, to reflect on the meaning of the emotions which are evoked by the professional difficulties, and to see problems and failures as opportunities to learn rather than as unpleasant events to erase from mind and memory.

Conclusions

In the present paper, we have suggested that the difference between a critical event and a clinical case represents a key training dimension. We have delved deeply into the exploration and discussion of the aim of clinical psychology – an aim that we have defined as the facilitation of a thought about the emotions which are evoked by the demand relationship. We have seen how important the thought about the emotions can be in order to give a sense to the emotions belonging to the relationship, so that a sense can be given as well to the problem which motivated the client the make his demand to the professional. Such a problem has to be put in the framework of the demand that is made to the psychologist, of the context in which the problem itself was born and in which the demand is worked out and analyzed, of the theories and methods on which the possibility to think about the emotions is based, and of the role played by the psychologist in the process. All these training themes inform the successive training stages which are aimed at fostering clinical psychological competence, and which are expected to bring the trainees from the knowledge of their own emotions within the clinical relationship with the client to the competence to interpret and help the client to give a sense to the problem he brought into the relationship with his demand.

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