Clinical Psychology

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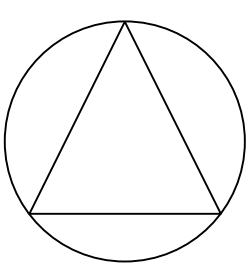
As has perhaps happened to others when reflecting on the subject of ' Clinical psychology ', we had been feeling a little lost. We read the definition our Collegio1 had put forward, well formulated in itself, and the situation looked no brighter: our epistemological ambition tottered before such breadth. We will therefore try to contribute some limited, discursive, dialogic ideas.
Today we find ourselves sharing a broader concept of the development of the mind, within which psychological factors (in both their intrinsic scope and in the breadth of the field of vision encompassing them) can be considered with greater clinical competence and from a relational viewpoint thanks to various clinical psychology models (analytic, cognitive, systemic-relational, psycho-somatic, etc) and to the contribution of other fields of study (anthropology, neuroscience, infant research, etc).
This is the direction taken, for example, by the mind-body-relationship model with which we have been trying for years to create a model to help with complex clinical thought, and which seems to have moved forward and matured, making the task of mastering complexity less difficult for us.



Alongside the role traditionally attributed to synaptic neurotransmission (Siegel, 2001), recent studies in the neurosciences (Pert, 2000) reveal the existence of a more diffuse, parallel extra-synaptic system (peptidic neurotransmission) which represents the biochemical substratum of the emotions. In the hypotheses of the well-known biologist Candance Pert, perceiving and freely expressing the emotions creates a dynamic, integrated psychosomatic equilibrium which corresponds to the person's state of wellbeing. When on the other hand the emotions are repressed, the biochemical pathways are blocked, impeding the flow of chemical substances, vital for our physical and mental health. In view of these exciting discoveries, which mark the definitive decline of the useless mind/body dichotomy, it is credible both to say that all illnesses can be considered 'psychosomatic', and to assert the centrality of the *relational* dimension which constitutes the real and imaginary scenario in which our emotive life unfolds (Lo Coco & Lo Verso, 2006).
The connection between these issues and clinical practice is so strong that an overlap is almost created between methods, perspectives and working objects.
In a certain sense, clinical psychology is first of all the *clinical psychology method*, i.e. a practice that unfolds in relational contexts defined by the subjectivity of the clinicians and their patients, by the relational situations that are created between them, by the worlds they come from, by the culture – in the anthropological sense – in which they are immersed, by the goals they set themselves, in settings created as *relational situations* where what happens can be experienced emotionally, thought and given a sense.
As such, the clinical psychology method is a relational method with its own disciplinary specificity which does not have much to share with the neighbouring disciplines, with which however it shows

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great integration at the level of knowledge, and often in working objects We share Carli's conviction that clinical psychology is a *science of the relationship,* but we feel the need for a definition that more explicitly includes among its objects of analysis, *the relationship underway at the moment of meeting, the participants in the relationship, the internal and external relational worlds in which they have lived and live, the relational and institutional context in which the relational situation unfolds*.

We also support the statement in our statute in which psychotherapy is defined as the domain that best characterizes clinical psychology; however, though we recognise that the two domains share considerable exchange and integration, we do not think they should by overlapped.

Clinical psychology has theoretical/methodological frameworks at its disposal and decidedly broader fields of application. In clinical psychology concepts that are also important for psychotherapy, such as the analysis of the demand, the field, the context, and the institutions, become indispensable. Issues like distress, diagnosis, the social domain, interpersonal relations, become the immediate field of work and of research for clinical psychology. Without these rewarding inputs, clinical interventions on the new frontiers of clinical-social work would be inconceivable, such as the support relationships in street work, consultations with the various types of teenagers in difficulty (antisocial, institutionalized, etc), i.e. untried clinical forms that increasingly involve us in the construction of 'new settings' which, if implemented through adequate, conscious clinical-therapeutic training, can produce innovations and stimulating knowledge leading to the reformulation of theories and techniques. Without a broad clinical psychology approach, we personally would never have been able to study the *mafia psyche* or understand the connections between mafia, the inner world, family and social world, and the anthropological dimension (Lo Verso, 1998; Lo Verso & Lo Coco, 2002).

Even though it has also recently benefited from knowledge coming from other fields of study, we feel all the same that psychotherapeutic work should be defined as a more *limited and specific domain.*

Psychotherapy is a process of treatment aimed at the wellbeing of single individuals and as such requires that in certain respects, attitudes and responsibilities of a healthcare type should be assumed. This does not mean that psychotherapy, and even less, that clinical psychology acts with methods and epistemological perspectives of an objectivistic-medical type. It works with relationships, subjectivity, feelings, emotions, meanings; nor can it benefit from following in the steps of 'mimesis orthopaedics' as Carli underlines, in the attempt to reduce the gap in people between an awkward functioning and the adaptation to socially accepted models of functioning.

However, psychotherapy, as we understand it from our daily practice, is not just the relational domain where the people who ask for it fulfil the need for an existential experience and for a rich and stimulating path of personal awareness. The people who come to us show, with different levels of intensity and awareness, suffering, illness and mental distress that can be considered relational disorders, connected to their inner and family worlds. These disorders cramp their growth and their vitality and prevent them from having, experiencing and feeling relationships with others in an authentic and satisfying way, resulting in limitations and psychological suffering.

We feel that it is of secondary importance to determine whether and how far these relational disorders can be attributed to diagnostic categories of a psychiatric type; in our view, what makes the clinical psychology approach to suffering more appropriate is the capacity, through the therapeutic relationship co-constructed with the patient, to focus attention on the aspects of the inner and family world connected to and implicated in the beginning of the suffering itself. It is by means of this attention, continuously adjusted by the therapeutic relationship, that the rigid, entrapping, invasive relational problems, and therefore the pathological problems of suffering, acquire meaning. In this way the ground is broken for the person's possible recovery, evident in varying degrees, of psychological and relational vitality.

In this perspective outside medicine's epistemological framework, the concept of *cure* and that of *healing* remain the indispensable foundations that orientate psychotherapeutic practice, its ethics and its goals.

With the acceptance of the function of curing mental suffering and the consequent assumption of therapeutic responsibility, we also associate our interest in research and evaluation and the importance that we place on some features of training processes.

Let us start from evaluation to briefly reiterate our well-known position of rejection and indifference towards research projects guided by reductive, objectivistic thinking, as well as towards the handbook style of treatment that results from these approaches being combined with economic interests.

In the last two decades it cannot be denied that the spread of research projects of evaluation of the psychotherapies in our scientific community has contributed directly and indirectly to significant changes concerning many aspects of therapeutic work, but also clinical work in general.

First of all, there has been a cultural change, seen in an increased capacity for dialogue, debate and exchange between different models and theories, often facilitated by having discussions based not only on empirically grounded evidence, but also on data that is contradictory, uncertain or hard to interpret, and on questions that are still open. Let us take for instance, the issue of 'common or a-specific factors': apart from an initial shock, the subject allows everyone to return to some of the commonplaces that were for many years our staple diet, like the fact that the importance attributed to the inner world is a question that concerns only analysts, or that the study of symptoms is found only in cognitive therapies.

The intersubjective debate on the subjects of research has in the last few decades helped the scientific community to regard psychotherapy as a *specific science* with its own peculiar *method of treatment* which as such must be able to communicate clearly and make methodologies, goals and results demonstrable.

In our view, the issue of the responsibility for treatment helps to make therapists more aware in facing up to the problem of efficacy, of instructions, of results and therefore helps to create an *ethical attention* towards what is actually done, what happens to the patients, towards the limits of models, and the therapy failures. A contribution to this capacity to observe oneself and one's own work has come from the shift in research focus – from the initial focus purely on the patient, it has moved towards the setting and the therapist, who creates and manages the treatment process, by means of which the patient's suffering can be understood.

In this direction, in our experience and in that of many respected colleagues, it has been useful for insight into clinical work to go beyond the analytical/psychiatric tradition that studies the case by focusing on the patient, as if a-contextual observation were possible, and to pay closer attention to *the setting,* the theoretical/clinical device and what underlies it, and to the fact that through the construction of the setting the therapist *creates* his work and through this 'reads' the patient, his/her story, and his/her suffering.

By adopting this perspective we have seen more and more clearly that in psychotherapy the procedural framework has specific features that must be recognized and made explicit. *The therapeutic setting does not exist in nature*: it is an artificial relational context, a cultural and conceptual construction typical of the west of the last century (from Freud onwards). As T. Nathan (1996) writes, the setting is a technical framework, a device entirely 'constructed' by the therapist in which what happens is conceived *as if* it were 'natural'.

The theoretical and the technical frameworks have the role of constructing a device within which what happens in the therapeutic relationship is part of an operation of sense construction *induced* by the device itself: *what happens in our work takes place and acquires meaning precisely because it is within a setting.* It is precisely this aspect of construction that characterizes it as a dimension which, being outside daily dynamics, makes it possible to create a mental space in which deep and meaningful psychological and relational matters are experienced and shared. Whether this mental field is dual or of a group, family or integrated, it is not defined once and for all, but it constructs and organizes itself through the network of communication shared by patient and therapist.

Furthermore, since the procedural framework is derived from specific theoretical, epistemological and clinical attitudes, it determines the visibility and the possibility of thinking the events that occur on the therapeutic scene: *the occurrences themselves change shape and meaning according to the setting in which they take place.* In fact, due to specific theoretical, methodological and clinical aspects, every psychotherapist focuses attention on models of attachment, on intrapsychic conflicts, on dysfunctional ideations, on corporeal transformations of the emotions, on group or family relations, and so on.

All this further underlines the importance of the therapist's capacity to reflect on the procedural and theoretical models being used, in order to adapt them better to the therapeutic situation in its

phases of evolution and transformation and to avoid hindering the process. (Di Nuovo, Lo Verso, Di Blasi & Giannone, 1998; Di Nuovo & Lo Verso, 2006).
In this perspective, our research group has in the last few years elaborated some empirical and clinical/observational tools for the interpretation, analysis and visualization of a set of variables that are of fundamental importance in relation to the group therapy process.
The aspects concerning the therapist as a person and the features of the relationship are important fields of enquiry which enable us to connect the question of research with that of training.
Various recent studies have, in fact, underlined the importance of the *subjective factors* involved in the process of treatment, as regards therapists personally: their psychological functioning and the quality of their emotional health, as well as the interest they feel towards the patient, emerge as factors that correlate with a positive outcome of therapy. This encourages us to place greater emphasis on the quality and the rigour of training processes, on the integration of theoretical and methodological contributions that can increase the competence and the capacity of trainees to observe their own work and to agree to be observed, to evaluate what is actually done, the goals and the results achieved. These aspects which make up professional competence, after all serve to strengthen the traditional components of training such as supervision and above all therapeutic work on oneself. The latter remains the main tool on which psychotherapy schools must in our view take a rigorous stand, avoiding dangerous shortcuts like that of believing that personal analysis corresponds to 100 hours in a training group in the school itself. On this point we feel that in the light of the studies on the therapeutic alliance and on the therapist as a person, even the most 'technical' approaches, like the systemic or the cognitive approaches, cannot remain indifferent to the personal problems of trainees.
Of particular importance, moreover, is the basic theoretical training given in the 'specialistic'[2] degree course which besides including open, modern theoretical components, must also provide epistemological awareness and competence (so that our methods of knowing will affect the knowledge of clinical work), competence in neurobiology (the effect of our work on the body and vice versa), in anthropology (the contextualization of clinical work and of the problems faced in it), in organizations and institutions (mastery of the factors making up the setting, a top priority in social/clinical work, and that in the community and in the public services).
In conclusion we believe that supporting the connection between clinical work, research and training can help to strengthen clinical psychology as a unique science.
The question should certainly not be posed in terms of achieving the mythical "objectivity" of clinical practice; however, we feel that having at our disposal scientifically recognized theories and methodologies that are capable of producing knowledge and top-quality results that can be shown and shared would be a great advantage in terms of the quality and efficacy of the clinical work and of the possibility of gaining scientific recognition.
The concept of science we are referring to is that of a "practice that is open to the intersubjective debate, that gives clear definitions of concepts and postulates, uses clear and repeatable procedures and adopts a rationally grounded method for the validation of theoretical hypotheses" (Di Nuovo, 1998). Within this concept of science, and in the framework of ideas opened up by the Paradigm of Complexity, clinical psychology is shown to be a scientific practice insofar as it explicitly states the theoretical and methodological frameworks that guide it, it indicates and describes, in as clear a way as possible, its aims and the characteristics that distinguish it, the context in which its specificity operates, but also indicates and describes the way of knowing or transforming the realities it works on, and the methods and tools it intends to use. On these parameters it is possible, in our view, to construct a methodological approach for a science that respects the complexity of the qualitative objects of clinical psychology, including psychotherapy
As we have repeatedly said, if psychotherapeutic work wants to be recognized as being scientific it must be capable of explicitly stating the frameworks, theoretical and epistemological models that it refers to, of defining in both a broad and detailed way the aim of its work, of indicating what aims it sets out to achieve, what tools it will use and as far as possible, what outcomes it intends to attain.
This is a particular type of scientificness about which we believe it would be useful to create an in-depth debate on the convergences and divergences, the limits and the potentialities in the most established clinical psychology approaches.

[2] Italian course of study at University

Lastly, these suggestions aim to contribute to another aspect that is relevant to clinical psychology in that it helps to promote the *ethical issue*: greater epistemological, methodological and educational awareness serve, in fact, to improve the assumption of problems and to design the planned intervention and/or treatment with greater clarity and precision.

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