Clinical Psychology: present and future

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1) "Clinical"

The adjective "clinical" referring to "psychology" has a very different meaning from its use in medicine today. The term "clinical" originated in ancient times, deriving from the Greek klinē, indicating the patient's supine position with the doctor bending over him. This representation contains the essence of the "clinical method", namely, the relationship of the doctor with the patient: a relationship which, considering the tools and the knowledge of ancient medicine, could not but be personalized, long-term, careful and intimate. The entire history of a person's life, the environment in which it unfolded, the life-style and the family context needed to be known, so that the doctor at that time could have some clues as to how to treat the patient. In other words the doctor established with the patient what the psychosocial services today call "shouldering the burden": "caring" rather than "curing", i.e. an individualized relationship and a purely longitudinal examination. This "caring" is carried out today for treatment involving the psyche, while present-day medicine seems no longer to need such a relationship.
Today, in fact, advances in biology, chemistry, medical-biological technologies and pharmacology have made individualized interpersonal relations superfluous: endless tests in the laboratory or carried out using sophisticated biophysical technologies enable the patient to undergo a rapid, precise transversal – no longer longitudinal – examination, leading to a clear diagnosis which usually corresponds to a precise identification of the cause of the pathology, and for which there is a suitable pharmacological, surgical or physical therapy. For these reasons the individualized interpersonal relationship found itself overshadowed in medicine along with the longitudinal examination. Today the patient is "examined" transversally by various specialists of the various parts and systems of the body. In this picture, "clinical" has lost, in medicine, the original sense of the ancient klinē: its meaning has changed, in that it refers to the treatment that medicine is currently able to provide and that does not require the interpersonal context intrinsic to the ancient klinē. "Clinical" has become the synonym of "therapeutic", in the sense of "curing", and no longer "caring".
The progress of medicine justifies the change in meaning of the original sense of "clinical": this sense has however remained in psychology. Here, in fact, the specific clinical object is a person's inner and behavioural distress, and this perforce implies a longitudinal study carried out through an individualized relationship in the long term. The meaning of "clinical" has therefore remained, in psychology, close to the sense of the ancient klinē, while this is divergent from medicine today (Imbasciati & Margiotta, 2004, chap. 2). The difference between the two meanings used in the two areas often creates misunderstanding.
There is an intrinsic logic in the separation. As a consequence of medical progress, with the related possibility of identifying the exact "illness" (previously one only talked about syndromes) and of therefore having a specific remedy available, the concept of the clinical nature and the very meaning of "clinical" necessarily had to change: in medicine "clinical" became synonymous with curative, and this synonymy is shown by the fact that each precise diagnosis corresponds to a precise therapy. The concept of diagnosis is after all based on the identification of an "illness" that has been studied enough to be recognizable, and of which the aetiology and pathogenesis are known: hence the value of a diagnostic nosography. Diagnostic situations of identified, known illnesses have corresponding and equally precise therapeutic instructions. This is "clinical": in medicine.
In psychology we are not faced with "illnesses", but only with possible syndromes. A syndrome is defined as the set of signs, or of symptoms, which are recurrently, but not always present together,

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but of whose recurrence neither the aetiology nor the pathogenesis are known. A syndrome can, moreover, have infinite variations. But above all psychology considers an even greater range of psychological situations, or rather psychological structures, or at any rate behavioural variations, which are part of so-called normality: Clinical Psychology deals specifically with the varied range going from normality - or rather, the best normality – to the anomalies that are considered pathological. In this continuum, the specific object of Clinical Psychology is made up of the unrepeatability of the psychic structure of the single individual: the concept of the syndrome, in itself changeable, is further invalidated; and the very concept of pathology, borrowed from medicine, cannot be transferred to the psychological. In medicine the concept is determined by biology, and by the acquired knowledge of "illnesses". In psychology on the other hand, since every psychic structure is determined not by nature, but by the sum total of learning by means of which each individual throughout his life has constructed his specific mind (Imbasciati, 2006a, 2006b), the normality/pathology polarity can only, if necessary, be anchored to the criteria of social and cultural coexistence. The issue has been widely treated in the literature (Imbasciati, 1993; Rossi, 2005). Here we can therefore underline that the transformation of medical models from Medicine to Clinical Psychology is totally inappropriate and therefore misleading (Turchi & Perno 2002).

For the above reasons, Clinical Psychology also needs to change the concept of diagnosis. This concept in fact refers to that of illness, and to biological, aetiological and pathogenetic knowledge. Hence the value of a diagnostic nosography. Such a classification cannot however be applied holus bolus in the psychology field. Here a nosography has a diagnostic use – in the medical sense – confined to cases where there are also organic concauses, or at least to cases where, in terms of syndromes, a specific pharmacological remedy has been found. Here however we are moving from the Clinical Psychology field into that of Psychiatry.

The boundaries between Psychiatry and the Psychology that is today described as Clinical are not clear. This contiguity is often overlaid with some confusion due to the fact that Psychiatry is part of Medicine, whose parameters and criteria it adopts. On the other hand, since its intrinsic object of study is the patient's subjectivity, Clinical Psychology is constituted of many different roots (Imbasciati & Margiotta, 2004, chap. 4) which therefore make it different from the medical-biological sciences in reference parameters, methodological criteria and resulting concepts. If one does not remember these differences, intrinsic to the nature of the specific object of Clinical Psychology, there is the risk of great confusion.

There is another factor contributing to the progressive separation of the meaning of "clinical" from medicine to psychology. Today's clinical psychology, dealing firstly with the intermediate range between so-called normality and what seems markedly anomalous, finds itself considering the possibility that 'shouldering the burden' may not only prevent anomalous relational and inner situations from occurring, but may also improve each individual who seems otherwise "normally" adapted. In the specific medical sector of prevention, use is often made of a shouldering of the burden based on similar models to those in psychology (Imbasciati & Ghilardi, 1993). However, especially in Italy, in dealing with alcoholics or drug addicts, for instance, it is often the prevention of relapses rather than a network of services providing real psychosocial support to improve the individuals, while waiting for a prevention at the level of root-causes. Consequently, in this sector, too, "curative" medical models prevail over those based on shouldering the burden aimed at improving the general conditions in which people find themselves developing. Scarcity of resources, on the other hand, force operators to concentrate on the most urgent intervention, where some anomaly or illness has already manifested itself. There is therefore the accentuation of the medical aspect of curing, which reaches its greatest heights in medicine.

2) "Misunderstanding of Clinical Psychology in the medical domain"

The above differences in meaning of the adjective "clinical" have given rise to many misunderstandings, still existent, between doctors and psychologists. In the medical domain the psychological disciplines were introduced only about 12 years ago. Previously the syllabus of the medical degree envisaged only one "optional" exam in generic "psychology", in which, like all the

non-compulsory exams, the student received full marks after reading about fifty pages: teachers of non-compulsory subjects had to attract students in order to keep their posts. The result was that a medical graduate had often never heard of psychology, or even worse, in view of the type of exam done, had a totally reductive, fanciful idea of this area of knowledge. Generations of doctors consequently grew up with a great misconception about psychology: these are the same generations of university teachers who currently organize the orientation of the medical faculties. Consequently, a frequent and at times substantial misunderstanding of psychology shapes the medical spirit and reigns supreme in faculties of medicine.

In these faculties it is often thought that psychology is little more than common sense sharpened by human experience, *savoir faire*, or powers of persuasion, and that Clinical Psychology is essentially this “psychology” applied to patients in treatment for medical-surgical reasons for whom doctors notice some “psychological problem”. Consequently doctors consider the work of clinical psychologists as an “auxiliary” function, serving to smooth out the difficulties they encounter with some of their patients (perhaps with the more intelligent ones?!), and they expect the psychologist to do so in the times that typify medicine today. These are obviously absurd for real Clinical Psychology; they are ironically referred to as “biblical” times by doctors.

Clinical Psychology is therefore seen as being a natural part of medicine: this is a “natural” and equally erroneous *a priori*, which, being merely implied, remains exempt from any debate or discussion, making the medical faculties impermeable to a positive change. Another implication is that psychology is an “auxiliary art” to medicine. It is seen as an art, not a science, and therefore is subordinate to the users, the forms and the techniques typical of medical science. This leads to another contradiction: if the work of the psychologist is presented in a scientific light, appropriate to the methods peculiar to psychology, it is criticised as being unsatisfactory in that it does not respond to the criteria of rapidity, efficiency and evidence required of medicine; and its preconceived auxiliary nature does not allow the psychologist to discuss with the doctor as an equal. .

Since psychology was formally included in their curriculum, and is now in a less formal way following the change in degree courses after the reform of Table XVIII, doctors tend to think that psychology operates with the same criteria and methods as the medical sciences. The psychologist is asked for a diagnosis and it is thought that, since there is a diagnosis there must also be an effective therapy. If psychology is a science, it must have – in the thinking of the medical model - a precise diagnosis and effective therapy. If it does not, it is not a science. The ambivalent outcome is that the psychological sciences, reduced to a single general psychology (or rather psychology “in general”), indistinct from Clinical Psychology, must cope with the expectation of being like the medical sciences and simultaneously with accusations of charlatanism when this expectation is not met.

Psychiatrists corroborate these mystifications in no small way: most of them are the most authoritative supporters (though they claim the opposite) of the inclusion (often under pseudonyms) of psychology as part of Psychiatry and often of the subordination of the former to the latter. In this way they reinforce among their medical colleagues the idea that Clinical Psychology is part of the medical sciences, and that the same parameters must therefore be applied to it. If this does not happen, the one who pays is the psychologist, who is seen as incompetent. He is therefore asked for the diagnosis with the various DSM editions intending however that this diagnosis, in contrast to the instructions of the handbook’s authors, should have the same value as a medical diagnosis (Spagnoli, 2005), and should similarly lay down exactly what is to be done.

So it is that doctors apply the adjective “clinical” to psychology with the same meaning that it has in medicine: with more than a few drawbacks, given the separation described. Clinical Psychology is supposedly then an essentially therapeutic form of psychology; to be precise, it is supposedly the psychological therapy. This misunderstanding is often deeply-rooted in the minds of many psychologists. In those of doctors there is also the understanding that therapy is specific and correlated to an “exact” diagnosis.

A further misunderstanding derives from the fact that therapy in medicine is essentially transitive: the doctor, active, “does” something (or has something done) to the patient, who is passively

subjected to the doctor's action (compliance). Psychotherapies are, in contrast, usually intersubjective. Many doctors expect the psychologist to "do something to" the patient, to prescribe like the doctor, to act *transitively* (Imbasciati 1993; Imbasciati & Ghilardi 1993); which ultimately means psychological manipulation. This at times comes down to the idea that the psychologist acts by "giving good advice", and that s/he has the ability to induce patients to follow him/her.
This state of affairs, originally attributable to the purely nominal presence and to the consequent mystification of psychology, still endures in medical training, despite the introduction of the psychological sciences in 1989: sectors PSI 01 and PSI 08 in the medical curriculum, and in the following years all the other sectors in the various health degrees. This formal introduction, however, had very little effect, because what was set down on paper by the legislator was not followed by adequate application. In the 1989 academic year Table XVIII was reformed, i.e. the subjects in the degree course in Medicine and Surgery, introducing General Psychology in 1st year, Medical Psychology in 4th and Clinical Psychology in 6th. The reform, later adjusted, has still not produced effects because, due both to the medical spirit and to the scarcity of resources, the teaching has not been assigned adequately to teachers with specific competences but is more often done through temporary contracts with teachers of medical subjects considered compatible (a recurrent example is Psychiatry, although the nomenclature of the sectors places it at a distance) or at least "declared" "compatible". As far as the other PSI sectors are concerned, in other health degrees, the posts are still to be filled.
Amid the general resistance to change typical of the institutions, particularly Italian institutions, in the medical faculties the misunderstandings on psychology described above were combined with the typical (practice of favouritism?) development leading to the multiplication of already strong teaching chairs, and in the meantime the progressive depletion of the funding for permanent posts: the overall multiplier effect means that jobs in psychological disciplines have not been set up even though the legislator had inserted them in the pathways of the various degrees. The reforms mainly stayed on paper. Psychology teaching in medical faculties is extremely limited, confined to General Psychology and, sometimes, Clinical Psychology, while the other scientific disciplines of the spectrum of psychological sciences are totally absent. Physiotherapists, nurses, trainers, midwives, health workers, speech therapists, psychiatric rehabilitators, and many others, as well as graduates in physical education, have absolutely none of the posts envisaged by the legislators in the various psychology sectors. The teaching positions in these subjects, laid down by law, are provisionally filled by dummy staff. The training situation is therefore disastrous. When a medical faculty decides to allocate their scarce resources to the establishment of a new teaching chair, the choice falls on a medical or biological discipline, not on one from the psychology field, even though this the most under-represented. There are no tenured professors, in any Italian Medical Faculty, of Developmental Psychology, Social Psychology or Dynamic Psychology, just to give a few examples of the subjects prescribed by the legislators for the new health degrees. Many of these degrees have become of five-year duration, "specialist degrees", like nursing, midwifery and others, and they will therefore produce "Dottori Magistrali"[1]. The percentage of permanent psychology posts compared to the number on paper for the whole of Italy is 1- 2%. And unfortunately, the percentage of the total number of permanent posts in medical faculties compared to all the subjects taught is not more than 5%. This seems to exonerate doctors with respect to psychologists: the resources are scarce and it is only right that they should go to the fundamental medical and surgical subjects. However, all this simply serves to prolong the misconceptions we have described, and to postpone the actual psychological training that doctors need and that has been so loudly proclaimed.

3) Who are the teachers?

In the situation that has been created, it seems logical to ask who the teachers are who have found themselves recruited in this way, what skills they have and how they can act as trainers for future

[1] Italian title for people who have a second degree from a university.

health workers. Many of the latter – it should be remembered - could in turn become the managers who will direct the future organization of university and Health Service. We should also ask ourselves what seeds these teachers sow to lead the present university spirit out of the mire of misconceptions regarding psychology, and to adequately show what the different psychological disciplines are so that their importance in student education can be understood.
In the best case scenario, a psychology teacher may take on the teaching of three, four, five or more subjects, and "unite" them. This means that he gives the same lecture to doctors as to trainers, or physical education students. But if we think of the needs of the various professional figures, the ploy is totally aberrant. Elsewhere I have discussed the need to set up diversified health psychology disciplines (Imbasciati & Margiotta 2004, cfr. Introduction and chapters 5, 6, 14). Otherwise temporary substitutions should be given for related subjects: a teacher of General Psychology, for instance, could also do Clinical Psychology; often "uniting" them. A psychiatrist will often do Clinical Psychology; or it may even be assigned to a specialist in internal medicine, with a "declaration of affinity" approved (unfortunately!!) by the Faculty Board. And again, and yet again, "contracts" are resorted to: external professionals, such as any ordinary psychologist, can become a "professor", on a yearly contract. Obviously many of these psychologists are happy to suddenly find themselves "university teachers", despite the merely symbolic pay (around Euro 1000 a year).
What motivating factors, as well as competences, do these trainers have? The faculties guarantee in their minutes that there is the necessary competence. Ascertained by whom? By a doctor or a biologist, evaluating a psychologist? And where do they find the time to "evaluate"? But that is not all: with regional agreements, the medical faculties give unpaid contracts to hospital or Health Service staff. What psychologist from some isolated country Health Service would not be glad to leave his workplace one day a week to be a "university teacher"? Naturally he could be called to teach General Psychology, or Dynamic, Social, Developmental, Occupational Psychology – what difference does it make!
Naturally, when confronted with this situation, the faculties deny everything and demonstrate with their minutes that the competences of these teachers have been properly assessed. Fifteen years ago, when it was still possible to apply some evaluation and in particular a certain selectivity, since the disproportion between permanent posts and temporary contracts was only just beginning, in an article (Imbasciati, 1993) I denounced the worsening situation: I provoked the rage and the threats of the Dean of the time. The medical faculties have their own specific pride, with which they defend their dignity as "doctors".
I have mentioned the disastrous university situation, which by the way is not specifically related just to psychologists, in order to underline how the aberrant ideas on psychology, which have crystallized through decades of total lack of information among the senior doctors who currently govern the universities, can still endure and be transmitted; on top of these misconceptions are added the strategies *made necessary* by the current lack of resources.
No wonder then that the reforms (well made!), that introduced psychological sciences in the training courses for doctors and for all the other graduates that are being turned out, have remained on paper. And that the spirit of the medical faculties is still impregnated with old prejudices and stereotypes. Consequently "clinical" still sounds unequivocal to the ears of the medical spirit, in the sense that it has in medicine, and being unequivocal, it is expected to be applied also to Clinical Psychology.
There is also another set of lasting misunderstandings. Medical Psychology is misunderstood and identified with Clinical Psychology and, due to the adjective 'medical', it is thought to rightfully belong to doctors, to be a form of psychology "naturally" part of their background, as long as their "sensitivity" is supported by hard work and good will. If it is practised by a psychologist, s/he is expected to adapt to the conception of the discipline held by doctors, i.e. that it must solve the "psychological problems" of some of their patients: these "problems" are however the problems of the doctors, faced with patients who require more space and attention than is normally provided in the current health service and its organization. Talking about a Medical Psychology focusing on the operator instead of the patient arouses enormous resistance (Imbasciati, 1993, 2006c), both emotional and rational; moreover, the organization will not in fact allow it.

This tangle of misunderstandings gives rise to institutional and legislative consequences at a national level: see the recent founding of a Specialization in Clinical Psychology grounded in Medicine and lumped together in a common body with Neurology, Neurophysiopathology, Childhood Neuropsychiatry, and Psychiatry: the "common body" restricts the specific scientific training of Clinical Psychology specialists, favouring competences that actually belong to the more precisely medical specializations. This contributes to maintaining all the misconceptions described above.

4) Medical categories

Other misunderstandings can be linked to the misinterpretation of "clinical", such as the use and the meaning of concepts like normality/pathology, illness, diagnosis, therapy, psychotherapy; there is still an idea of a linear cause and effect relationship between aetiology and pathogenesis; and on the very term 'patient': is it really the sick person, as in the etymology, "he who suffers"? Or is it simply a user whose expectations must somehow be fulfilled? Or perhaps it is just the number of a "bed". The question is broad and complex and has given rise to numerous debates (Imbasciati, 1993, 1994; Turchi & Perno, 2002), on the essence of Clinical Psychology (Imbasciati, 2004, 2005) and its relations with medicine (Imbasciati & Margiotta, 2004).
In psychology, "clinical" essentially indicates a process of shouldering the burden involving knowledge of the single individual, in his history and his structure, that can get no benefit from typologies (vainly tried in the past) that are applied both to the "normal" and to the so-called pathological. In this process, the relation that is constructed between the knower and the known always and in any case has the value of an intervention, not in relation to a specific syndrome (the supposed "pathology"), but in relation to a restructuring of the personality. Given the unrepeatable nature of the single individual, whether he be judged normal or pathological, the strictly idiographic knowing process takes far longer than in medicine and it cannot exist without a personal intersubjective relationship, established between the subject known and the operator. It is a type of interpersonal relationship that simultaneously acts as knowing process and as therapy. Obviously the operator needs to be a clinical psychologist, scientifically trained in an appropriate manner.
For these reasons, in psychology, instead of talking about diagnosis, which recalls the medical sense, it is considered preferable to refer to a *dia-gnosis*, in the etymological sense of the term, that is, "knowledge through" (Imbasciati & Margiotta, 2004 cap. 5). If one does not want to resort to the esoteric "assessment", such a process could be called "e*valuation"*, but the term might be misunderstood, in a pedagogical or ethical-moral sense, and might overshadow the specific essence of an individualized knowledge, extended in time, involving a relationship, and intrinsically implying a shouldering of the burden. It is therefore always a therapeutic interaction, rather than iatrogenic, as can also happen. The intervention therefore does not rely on specific techniques that act like drugs, but rather it is intrinsic to the relationship, for better or for worse. In psychology one can talk about therapy, about "treatment", but in a very different sense from medicine, in other words as the direct result of a previous, but also ongoing process of knowing: "emotional" knowledge, whose complexity has been the subject of massive research (Imbasciati, 2005b, 2006a). The type of such knowledge determines the quality of the "treatment", i.e. the type of effect that the shouldering of the burden produces in the operator and the user.
In medicine knowledge of the illness is pre-existing, in the sense that the huge volume of preceding studies have identified the different illnesses and one can therefore proceed to the therapy for the particular illness identified. Hence the value of the diagnosis and the medical-surgical nosography. Consequently the intervention can be carried out in relative detachment from the diagnosis, once the diagnosis has been made. Psychology cannot make use of reference typologies that, once identified, indicate the type of therapy to follow: knowledge and therapy overlap, in infinite interpersonal situations, unrepeatable just like each single individual. In psychology, dia-gnosis, relationship quality and the possibility of shaping the subject's situation are all one. In fact one should not talk about 'cure' in the strict sense, especially when working with subjects who to different extents fall within the range of so-called *normality* (even more so if the objective is to promote health), but only about shouldering the burden, about "taking care of". It can also be misleading to talk about 'intervention', since this term contains the planned and pre-ordained action

of the operator on the patient, in a transitive interaction (Imbasciati & Margiotta, 2004), which sees the active operator and the passive subject (*compliance*): psychological therapy cannot be conceived as transitive, and even less as prescriptive; it is always an intersubjective interaction.
Clinical Psychology, then, means the knowledge of the psyche of the single subject through an intersubjective relationship, which uses the operator's "equipped subjectivity" to develop a better subjectivity in the user. The concept of "equipped subjectivity" underpins the specificity of the scientific training required of a Clinical Psychologist, with specific, personalized training courses. A clinical psychologist is not constructed merely with the professional experience of a psychology graduate who works in the health service. This is even truer if his therapeutic operativity is expressed in some particular psychotherapy. In this type of operativeness today in Italy there is a mixture of abusive practices, some legal, some less so, and of enormous confusion, both when it is practised by psychologists, even more so when other professionals, including doctors, claim to practise it.
In the present Italian situation, from the cultural, scientific (or pseudo), organizational, and welfare point of view, Clinical Psychology is fertile ground for misunderstandings and "invasions" by other professionals, unless perhaps all those who work in assistance believe they can act as psychologists, and by this they mean the clinical psychologist. We've all got something of the psychologist! Hooray! All you need is good will, and "sensitivity"! This last word includes and conceals everything. And also Psychology graduates are filled with confusion. The contaminations that reign among doctors seem to have also spread to the Faculties of Psychology and to the new psychologists. Many believe that to be scientific Clinical Psychology must be essentially (maybe only) based on experimental proof: not experimentation in the field, but in the laboratory. A misconceived objectivity is transformed into objectivism and deletes the process of validation of the operator's subjectivity (Imbasciati & Margiotta, 2004 chap. 1, 6, 22). An internal debate is raging among psychologists, between those with a biological orientation and those who prize the subjectivity of the operator and the patient in their reciprocal intersubjectivity, as the prime tool of the clinical psychologist. It is an instrument that must obviously be constructed and calibrated by his training. But is such training being increased? Or is it being progressively stifled? Isn't the biological orientation that is spreading among some psychologists perhaps a shortcut to avoid training? And to opportunistically jump on the bandwagon of the doctors, or at least of the health organization? Between an *impact factor* and a standard deviation, are we heading for a psychology without a soul? (Figà Talamanca, 2004; Colucci, 2004; Imbasciati, 2006c).

5) In the faculties of Psychology

Among psychologists and in faculties of Psychology a process of dehumanization is underway affecting the disciplines that should have the most contact with human subjectivity, i.e. those usually included in sectors MPSI 04, 05, 07 and above all MPSI 08, or Clinical Psychology. The process seems to be syntonic and can be likened to what permeates the medical faculties and is perhaps linked to an overreaching medical spirit that tends to invade neighbouring fields of study. However, deeper, perhaps more worrying roots can be discerned. Psychology faculties in recent years have been swamped with an ever-growing tendency to exalt experimentation, or rather, psychology studies carried out in the laboratory, in connection with biology, neurology, physiology and neuroscience in general. These disciplines are called psychobiological and psychophysiological: extremely worthy disciplines that are indispensable for global progress in all the psychological sciences. However, this "emergence", sheltering under the aegis of "pure" science, is overshadowing the importance of the other disciplines that operate not in the laboratory, but "in the field", with live people, groups, collectivities, where the research does experiment, but in natural conditions in which humans and their conduct can be "observed". This emergence above all devalues the disciplines that actually involve constantly shouldering people's burdens. This "overshadowing" translates into stifling the growth of Clinical Psychology (and to a lesser degree of Developmental, Dynamic and Social Psychology), in that, due to the loss of value suffered by the disciplines involving more direct intervention, the already scarce Italian resources are channelled

into the sectors (usually MPSI 01, 02, 03, perhaps 06) of disciplines operating with the “exact” tools of the laboratory.
How does this happen? Obviously when resources are limited, various groups fight for them: in times of famine one comes to blows. It is also obvious that every sector looks after its own interests. But what is happening is that the psychology teachers who have the responsibility of shouldering the burden of patients, groups, institutions, with all the encumbrances (like time required for psychotherapies) involved in assistance, have the least time (and are less able to exploit the right moment) to throw themselves into the melée and make their weight felt to seize resources. The “laboratory” psychologies, on the other hand, rely on a tendency that is permeating the entire scientific and operative world of mental health: the use of evident, concrete means, which most people appreciate, and which are above all rapid. Effective? Admittedly, the efficacy has to be “demonstrated”, but the demonstration must be short-term and translatable into figures. So-called evidence-based medicine very often presents figures that are circumscribed and short-term. Many psychologists are following this trend, which satisfies the expectations of most of the users and facilitates (also economically) the work of these psychologists, making it undoubtedly more “convenient”. People’s expectations, on the other hand, are created by the current culture which with its competitive, frenetic rhythms and barrage of mass media has inculcated in people’s minds the idea that “Science” today can do everything immediately and rapidly.
There is therefore a vicious circle between present culture with its stereotypes, its media, its rhythms of life, and scientific research, especially in its applications and the consequent selective idealization of partial aspects, in keeping with the culture itself. In other words there is a sort of creeping collective imperative: “stop all the talk about feelings, human intimacy, the value of a real interpersonal relationship! Today Science can provide concrete, evident, objective, rapid solutions for mental health”. What is meant by health remains to be seen: whether it is really “mental health” or a mental order in keeping with the culture of the majority[2]; whether health is really promoted, or whether there is simply the correction of some “twistedness”, or some more glaring deficit.
The combination of all the above factors is creating in the faculties of Psychology a climate in which the Clinical Psychology that “is worth it”, the really “scientific” type, is the sort that makes use of the laboratory, of the neurosciences, of biology. All this is at the expense of the training of future psychologists. They in fact emerge from the faculties with a certain idea of Clinical Psychology, namely that it is for them and for others, what is more specifically called Clinical Psychophysiology, and what is more generally called Psychobiology and Neuropsychology. This is compounded by a further mystification: the Italian ministerial classifications of Scientific disciplinary sectors place “Clinical Psychophysiology” in MPSI 08. The use of the adjective “clinical” however reflects the medical concept of “clinical” that we have criticised, and that we believe is harmful to the autonomous growth of Clinical Psychology apart from the medical sciences. The inclusion of the above denomination in the statement of what is bureaucratically defined Clinical Psychology (could it be deliberate?), has resulted in a drain of teachers from sectors MPSI 01 and MPSI 02 into sector MPSI 08, and in a marked strengthening of the attitude examined here which proclaims as truly scientific only the Clinical Psychology based on the Neurosciences: the other approaches are scorned and their methodologies refuted.
These approaches and methodologies are in actual fact simply more difficult to master. And there are very few who really master them; those who with some presumption, claim to have mastered them (and there are a good many!) are dealing a winning card to the “psychobiologists”.
All these collective dynamics come about - and this is the tragedy - in perfectly good faith on the part of their advocates. This good faith can often produce intolerance towards different approaches and methods. So even in the M PSI 08 sector abuses are being perpetrated.

6) What is the future of Clinical Psychology?

[2] Some psychologists may remember the old debate in the ’50s on the concept of adaptation: “success”? Or “process”? (Lazarus, 1961).

In some faculties, in order to share out the scarce resources, scientific work is assigned points according to criteria drawn up by a commission: these points determine whether a certain teaching chair has enough funds to somehow or other continue its research; otherwise, the research has to be abandoned. However, these commissions are made up of teachers who, for the reasons explained above, mainly campaign for a biological slant in Clinical Psychology. As a result the teaching chairs with different approaches languish, their productivity plummets, or suffers a death blow. So for instance a short article adopting a psychobiological approach published in a journal with a high impact factor may be worth ten times a good book of one of the "other" approaches to Clinical Psychology.
Is the case I have argued in the previous sections, to free Clinical Psychology from its servitude to the parameters of medical science, destined to fail? If psychologists in the faculties of Psychology understand scientific-ness in the way described, then the "clinical" concept will be standardized to its sense in medical sciences. The same will happen to other standardizations of other concepts: normality/pathology; illness; diagnosis; therapy and so on. And in the same way, will the concept of interpersonal relationship in the doctor/patient or psychotherapist/patient therapeutic situation become so simplified and superficial that it is distorted? What "contact"? It will be said that it is enough to talk, to say the right things to the patient so that he can clarify his ideas, it is enough to instruct him, to play the pedagogue, to prescribe the correct remedy.
And what if the patient does not do what the therapist found obvious, and explained? And that the patient himself said was appropriate? If this patient finds himself saying "I don't do what I want, but I find myself doing what I didn't want to do!"?[3] Perhaps drugs will be used then, in cases where the force of affects and emotions has not been wiped out by explanations on internal cognitive strategies. I hope that this type of possible success is long term. But it is not easy to believe it.
The circle closes. What psychologists will we have in the future? What clinical psychologists? Will their professional work involve a shouldering of the burden? "Caring" and not the inevitably medical "curing"? And what will the conception of Clinical Psychology be? What will its statute be, and its role among health sciences? And then, what will this "health" be?
The reader will forgive my obvious pessimism. I hope I am wrong. It was in the wake of such considerations years ago, that the "College of Clinical Psychology Teachers and Researchers of Italian Universities" was set up. Its statute was deliberately designed to define Clinical Psychology, which, despite its many branches, must be preserved from the encroachment of orientations typical of other disciplines. It was also designed to guarantee its autonomy in research, but consequently also in the profession. I do not know what the future of this association will be: that depends on the extent of permeation by the overflow of teachers from other scientific areas, who will change rather than preserve the features of what will still be called Clinical Psychology.

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[3] We could quote St Paulus and St Augustine.

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