

For a relational grounding of clinical psychology. The consultation with the couple.

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Introduction

There have been various definitions of clinical psychology attempted by many authors. Among them we remember, in our country, those of Musatti (1953), Galimberti (1992), Lombardo and Foschi (1999), Sanavio and Cornoldi (2001), Carli and Paniccia (2005). Here however we will concentrate on two definitions of clinical psychology, one by the American Psychological Association (Division 12), the other by the Collegio dei Professori e Ricercatori di Psicologia Clinica delle Università Italiane.¹ They will serve as the anchorage for our discourse on the present state of clinical psychology.

In the first case (A.P.A.), Clinical Psychology is seen as a theoretical-practical field aimed at understanding, predicting and alleviating maladjustment throughout life (disability, discomfort). This is possible when clinical operators take into consideration the biopsychosocial variables inherent to the life of the individual. In particular, the psychic is seen as a cognitive-emotional, behavioural component. The definition also reveals a preoccupation with the view of individuals' differences in culture and socio-economic status, as if to recall that in the past clinical psychology scientifically supported these differences.

The other definition focuses more on the method than on the field. The method is related to the taking on of the "case" (be it an individual, a couple, a group, an organization) in an intersubjective-dialogic perspective. This means that clinical treatment with a psychological bias has the constraints, and the opportunities, of a meeting between persons, thus differing from medical treatment characterized by a nosographic-instructive vision. This is true both of diagnostic work (a process of knowing requiring involvement),² and of the attitude to the pathology seen as the way in which suffering manifests itself and which has a plausible sense in people's relations and life situations. The pathology is therefore anything but mere deviation from predefined social standards.

The comparison clearly shows the differences in epistemologies that orient and shape clinical psychology. There are those who are interested in "stress and coping", aiming at individual adjustment, but also at well-being (well-being therapy) and at personal development (positive psychology) and there are those who focus on the relationship with the other and the life situation (the context) using it as the place of treatment.

It must be said that due to some of its post-positivist presuppositions, the earliest form of clinical psychology finds it easier to dialogue with the world of medicine. Rehabilitation, adjustment, and increasing of the clients' potential using the results of scientific research make up, in fact, the crucial actions of this approach, actions which are easily integrated with clinical procedure in medicine. On the other hand, we wish to underline that making the relationship with the other and his life situation become the place of treatment, does not by any means involve locking oneself into transference-countertransference and modelling the world as an exact copy of the client-therapist relationship, although this reductivist view still exists.

In short, the world of the client is brought into play by both approaches, but the aims of the clinicians are significantly different: in one case in fact the aim is to "learn" something new (to

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¹ Cfr. Final Websites.

² Umberta Telfener (2003) distinguishes between diagnosis of the patterns of connection (analysis of the demand), diagnosis as observation of systems (observed-observer) and diagnosis of the diagnosis (reflection on the categories giving rise to the diagnosis in the perspective of clinical responsibility). In short, the diagnosis is incorporated in the *context* of the clinical relationship and is considered an operative choice characterized by criteria of usefulness and epistemic coherence.

communicate, express and control emotions, and so on), in the other it is to “get involved” in the relationship, understanding not only its problems but also the resources available. What they share is the recognition that clinical psychology does not coincide with psychotherapy, which is just one of its possible expressions.

There are numerous instances of intervention in which the request for psychological care on the part of individuals, couples, families and groups is not necessarily connected to the pathology. There are also cases in which there is no direct request for care despite the presence of a pathology, and it is up to the clinician to indirectly recuperate (through children, school or working life, court mandate) the possibility of dealing with the denial of suffering. We can therefore say that from the social point of view there is a greater need for a clinical attitude and intervention than for psychotherapy proper. After all, Cesare Musatti (1953) many years ago already maintained that the clinical method is not necessarily connected to the pathology or to psychotherapy.

Now, the contribution that we wish to make to the debate concerns the orientation that can be called “relational”. We will do it by identifying two pillars: *action* and *evaluation*, focusing on the elective domain of the relationship of the couple in the clinical context. This is in fact a very important *present* (and a promising near future) of clinical psychology.

While it is true that family therapy in Italy has always included very important psychotherapists and schools of psychotherapy, it is also true that the clinicians rarely grasp the opportunities for relational health that can emerge from the clinical encounter with the couple. It is through such an encounter that we can involve not just the partners but also the members of the original family. Moreover, it is always by starting from the relationship with the couple that groups can be formed focusing on specific themes (the management of divorce, the effects of divorce on the children, the illness of a member, and so on).

The direct relations with the families are more difficult. We believe that this is due to cultural reasons which must be taken into account. While it is true that there is strong professional and social resistance to recognising that clinical care does not coincide with the care of single individuals (the schools of psychotherapy themselves are the main propagators of this symptom), it is also true that it is Western cultural history that places the couple far more than the family at the centre of relational life. We can go so far as to say that it is through the couple that family relations can be recovered, in the sense of the exchange between generations and the transfer of bonds and their quality from one generation to another, a transfer that largely takes place in modalities typical of an unconscious logic.

The *context* that interests us and that must be taken into account is therefore related to the culture, the place of living (geography), the history and vicissitudes of the couple relationship both in the sense of the relation between partners, and as a parental-generational bond, with all the constraints and resources involved.

The pillar of action

The clinical intervention implies a process of reflection about the relationship with oneself and with the other. The *other* is to be seen as a class, in the sense that it involves not just “you” compared to “I”, but also “yours” and “theirs” compared to “ours”. The “other”, must also be seen in a generational sense, acknowledging the existence of ancestral presences operating both in people’s representational and their intersubjective worlds. Ignoring this aspect of psychological life means supporting interactionist reductionism (the visible and *hic et nunc* of the exchange) instead of relational complexity. The Self is therefore inhabited by the other and the other constitutes the inescapable horizon of the Self.

However a process of reflection without the energy of action risks narcissistic closure, a modality of mental functioning that colludes with clinical intervention. It is no coincidence that clinical work favours the representational aspect and sees in the world of action above all the danger usually codified as *acts*, either against the other or against the self. The other side of the coin is the psychological conception of action, seen as a set of plans and rational strategies aimed at achieving clearly defined aims and in which the emotions must be kept under control.

Admittedly, communicating (when saying is doing), conversing (expressive argument and “happy” dialogue), narrating (making a story therapeutic by constructing variant meanings), “pillars” of clinical practice, have in themselves the language of action, but they by no means exhaust it. What

is in question is in fact the person's decision making (responsible choice) and the initiative to make a commitment towards the self, the other and the bond in itself.

Even someone like Lacan (1966) who made language the central nucleus of clinical thought recognised that it is the *act*-action that generates certainty and personal development.. It was however Lewinian social psychology that indicated action as the key principle of human relations. In a time of domination by experimental research, Kurt Lewin (1951) maintained the value of another method, that of doing research while one intervenes, thus giving space to active action that transforms people and groups.

What we mean is that the clinical attitude risks reducing the world of action, on the one hand, to *acts* and, on the other, to control and rational planning. In reality, if human action is not considered in its unconscious dimension, but also in the ethical register that characterizes it, then it is clinical intervention that will suffer.

A borderline concept between mind and body, between individual and context, between subjective and objective, as sustained by Spagnolli (2003), action is seen by us in the sense of *drama* ("dran", fare) in which persons (the partners) participate, but to which they are also subjected. The relational drama is based on the presence of *difference* between the sexes (male and female), between the family histories, between the cultures belonged to, between the individuals' representational worlds (intentions, needs and expectations).

For us this is the context in which the couple's relationship works, a context of management of differences and therefore characterized by conflict and the search for possible conviviality, or as we prefer to say, characterized by the *pact*. The pact, unlike the contract, has its own "mission" albeit implicit: it is that of searching for peace and making peace ("pax, paciscor") between men, starting from the couple. Shouldn't we, as clinicians, therefore deal with the feeling of peace and its antagonist, the feeling of discord?

The bond of the couple that is formed can be constructive, suffering, destructive. It emerges in its particular quality at critical moments of the relationship (forming the couple, expecting a baby, experiencing the illness of a member) and this quality manifests itself through cognitive aspects (beliefs), affective (emotions and feelings) and ethical aspects (acting fairly, making up for mistakes, forgiveness and reconciliation, or their rejection or their impracticability).

Edgar Morin (2004), who dedicates the sixth volume of his impressive research on "Method" to ethics, has recognised that it has a noun of its own and its own specific action: *bond, to bind oneself*; binding oneself to family (belonging), binding oneself to others (strangers), binding oneself to mother-earth. While on the one hand the verb is reflexive thus referring to personal choice and engagement, on the other, the bond, as a noun, cannot but be the product of dialogue and reciprocity. What can each and all of us do for the bond? What can we give to the other? Are we capable of running the risk of being misunderstood and rejected? Can we go beyond revenge (blood calls for blood, just as injustice calls for injustice)? It is therefore in the dramatic spiral of the couple's relationship that we must look (along with fear, anguish, hope and trust) for the ethical dimension.

In order to fully consider the couple's relationship it is necessary however to go beyond the principle of reciprocity between partners. In fact the bond itself is in question. This level of the "relational" is almost misunderstood by clinical psychology. This is due to the fact that it is intersubjectivity (one partner towards the other) together with the representational (beliefs and lived experiences with respect to the other) that "saturates" the mind of clinicians. In short, focusing on the bond as the *third* party compared to the couple (joint product of the history of the relationship and its vicissitudes) constitutes an exception in clinical work with the couple.

The bond in itself is not however in the hands of or under the control of the couple, as if the couple were purely self-referential.³ The couple in fact is an interlocking of generational stories and in this way it revives and re-actualizes the world of bonds. We could say that the couple moves between prolepsis and analepsis, in the sense that while it acts in the here and now of life, it embodies the past of bonds and it moves towards an expected but uncertain future. Precisely because it is a coming together of stories and bonds, the couple does not repeat the past and is not affected by it, but instead opens up towards the new and the unexpected.

³ "Self" belongs to the heritage of cognitively oriented clinical approaches (self-efficacy, self-realization, self-monitoring, self-control) centred on the individual mind and its "happiness".

On the question of the *interlocking* of the couple we have carried out various researches over the years and designed tools for recording data (Intervista Generazionale, Spazio di Vita, Test delle Immagini, etc.). Here it is sufficient to recall the research into the connections between the couple's relationship seen as an interlocking and relaunching of generational stories (of bonds) and the development of personality disorders in the younger generations. In particular, it is the interlocking of *discord* and the interlocking of *juxtaposition of pain* that seem to constitute the matrix for the suffering of a generation that "falls" on the children.

In the first case the partners are similar in claiming the right to receive, because they did not receive attention and recognition from the preceding generations. Paradoxically they defend themselves from this by believing that they are self-made; it is however from each other that each partner unconsciously expects to receive what was missing in terms of care. They end up consuming the energy of action in the mortal battle with each other (discord), to establish once and for all who has the right to receive, and refusing and delegating the task of parenting. What happens then to the following generation? They find themselves "fatally" endowed with the right to receive (exactly what was missing or suspended in the generational exchange) and at the same time left to their own destiny.

In the second case the partners both emphasise the idea of being destined to a life marked by pain, to which all men are fatally exposed. In short, destiny ("kairos") has been malign and unfair with them. It is no coincidence that it is difficult, if not impossible, to find in their life stories any positive source of identification. The energy of action is therefore used up waiting for the children to be the "saviours" to make reparations for their painful destiny. In other words, there is a generational inversion in the sense that the children are placed in the position of the previous generations.

The first matrix corresponds to a path of Self development open to narcissistic and antisocial personality disorder, while the second matrix corresponds to a path of development open to the field-dependent personality and borderline personality disorder. It should be stressed that these are "open paths", but not rigidly determined. There are varied and complex factors that contribute to establishing a personal identity and to marking its development. Constructing *relational hypotheses* of health-illness of people considered in the context of their lived worlds is after all important in the clinical consultation. We are therefore dealing with a different method from the descriptive-nosographic approach of the DSM which is of no clinical use because nothing is stated in aetiopathogenic terms⁴.

Let us sum up: the first cornerstone of clinical work on the couple's relationship is made up of the *joint reflection* by the partners on beliefs and feelings about the bond, including their historical-generational aspect; the other cornerstone is constituted by the *energy of action* towards the other and towards the bond in itself. The responsibility, fairness, loyalty of the partners (the "ethos") are waiting to be regenerated and this can only happen through their reciprocal action.

The "ethos" must not be confused with the "nomos"; while the latter concerns the system of normative *rules*, the former concerns the optative (what is desirable in the relationship) that is manifested through specific actions like those outlined above. The clinician, too, is involved in the ethical dimension of the relationship in the sense that he is responsible for establishing the setting and for implementing the course of care for the couple, and has an important role in evaluating this process.

The pillar of evaluation

What can be said about research into the clinical consultation with the couple and the evaluation of this relationship? We must acknowledge that clinical psychologists, whether working in public services or in private practice, are rather unwilling to carry out the task of evaluation. On the other hand academic research does little to encounter concrete clinical activity. Both because of the modalities used by the research and due to the setting in which it is carried out (health facilities and laboratories), it is rather difficult to have a productive exchange with a clinical psychologist

⁴ It is no coincidence that there are various research projects aimed at constructing diagnostic categories in an interpersonal-relational key. Among others we wish to recall the research of Corrado Pontalti (1996, 1999) and of Valeria Ugazio (1998).

operating on the field. Moreover, most academic research concentrates on individual cases, having a dominant cognitive-behavioural orientation.

In short, there is little trace of clinical relationship with the couple and even less of the relational approach. This too is an aspect of the *present* state of Italian clinical psychology worth thinking about. The training situation is no better. There are very few psychotherapy schools that devote specific attention to the clinical work with the couple and training proposals made by ourselves and others are seen as “residual” compared to clinical work with the individual, but also with the family. We are therefore faced with the paradox of a more and more pressing demand and significant problems in satisfying that demand.

We believe that the training of clinical psychologists should envisage their involvement in various “genres” of care (relationship with single individuals, couples, families, groups), and their ability to understand differences and connections. Training that aims to sensitize a “single eye” is not helping clinical work, whatever its orientation is - cognitive, psychodynamic, humanistic or systemic.

For our part, over the years we have carried out research into the relationship of the couple with particular reference to the evaluation of the intervention. For this purpose we have drawn up grids, techniques and tools of analysis consistent with the relational paradigm. (Cigoli et al., 2003, 2005a, 2005b; Molgora, 2005; Margola et al., in press).

But let us take a step backwards. We believe the researcher must take a stand on research traditions related to testing and evaluation of the clinical intervention and psychotherapy. Now, there are substantially four of these traditions: the first is oriented to studying *efficacy* (research into outcomes);⁵ the second to *efficiency* (research into the process or pathway of care); the third to *abandonment* (research into drop-outs); the fourth to *instructions* for treatment (research into empirical evidence and treatment based on manuals).

As far as the “relational paradigm” is concerned, we have already explained that for us it means dealing with the *context of bonds* (“re-ligo”) of which people are part and of which they are agents: generational bonds, cultural bonds, intersubjective bonds, but also bonds with the geographical and historical environment.

According to the dialectic logic underlying the relational approach, it is within bonds that it is possible to identify not only the problems but also the resources to deal with them; these resources must be identified during the clinical relationship with the couple (the partners and their bond) and not in the abstract.

Now, what decision have we made on designing research into the evaluation⁶ of clinical work? The design should certainly focus on the *pathway of care*, also including the important issue of drop-outs. We feel in fact that clinical psychologists are interested in looking closely at the factors that mediate relational transformation, as well as constructing new relational hypotheses. On this, Beutler (2000) has talked about “mediators of change” and Norcross (2001, 2002) of “empirically supported therapy relationships”.

Among the noteworthy themes linked to the pathway of care we wish to underline two: the first is the *involvement* of the clinical psychologist in the action of taking care; the second is the consideration of the couple’s *bond* in itself.

In general the involvement of the psychologist is considered through the construction of the alliance and measured with grids and/or questionnaires (Friedlander et al., 2006). We start from a question about *if* and *how* the therapeutic bond comes to be formed and whether it is capable of resisting the inevitable crises. It is here, in fact, that the strength of the therapeutic alliance “is measured”.

⁵ Fonagy and collaborators (2002) elaborated a system for measuring the outcomes of treatment in terms of five domains of evaluation: symptoms, social adaptation, mental functioning, transactions (family functioning), use of service (and the perceived satisfaction). The measurement system is based on a logic of the *deviation* between outcomes and objectives. We propose another logic focusing on the *relational context* and its quality (development of resources that promote conviviality, i.e. the bond between people).

⁶ The evaluation and the result are different from each other. The evaluation is related to the clinical pathway, while the result is based on the expected outcome. In the first case, the type of research is qualitative, focusing on molar variables (cfr. Pinosof, 1981-1991; Altheide and Johnson, 1994; Patton, 2002; Di Nuovo, 2005).

We believe, in short, that the thread of the therapeutic alliance unwinds, or gets tangled, through “crucial moments”, no more or less than other vital bonds, and that these moments concern the coming together, the commitment, the crisis and the dissolution of the relationship. The question is therefore: is the “working group” formed by the clinician and the couple able to cope with the various moments, especially those of the crisis of the alliance?

It follows that the researcher must concentrate on these happening-moments. His aim is to provide the clinician with meaningful reflections elaborated on the basis of analysis grids concerning the molar variables inherent to the bond between couple and clinical operator and its history.

The other issue is the consideration of the couple’s bond in itself. Now, if we review the research into the psychotherapy of the couple, it is easy to see that in general the procedure used is the summing up of the points of view of the single partners but more rarely of an evaluation of the interaction (a simplified variant of the evaluation of family psychotherapies). In actual fact, focusing on the relationship involves giving space and importance both to the interpersonal dimension, and to the dimension of the bond in itself.

In the first case we consider the cognitive, affective and ethical modes characterizing each partner’s relationship with the other; in the second we consider the quality and the characteristics of what we call the “couple’s pact”.

To identify the features of the interpersonal relationship we can use both questionnaires and tools based on visuals⁷ that serve to trigger dialogue between the partners. Concerning the “pact” and its quality we can use tools such as the “Couple Life Space”, or the “Disegno Congiunto” (*Joint Design*) in which the couple work together on the same task.

While these tools serve to give us a way into the couple’s relationship so as to consider certain features, it is clear however that it is the *treatment of the relationship* that must be placed at the centre of attention. Hence the need to record the couple-therapist exchange “live”, using analysis grids to study how the therapeutic bond evolves and how it affects the couple’s relationship.⁸

Whether we start from the therapist’s contributions or from the exchange between the couple, what is highlighted is how the “working group” functions and whether it tries to increase the level of awareness, responsibility and conviviality. In fact, even when the couple’s bond ends in dissolution (as in divorce) it is always a matter of negotiation and of conviviality, i.e. of hope and trust in the relationship and in fairness in the exchange between partners.

Conclusions

Some time ago von Foerster (1987) said: “The hard sciences are successful because they deal with soft problems; the soft sciences limp along because they get the hard problems” (p. 207). Faced with the limping along (like Oedipus) typical of the clinical method, there is the recurrent temptation to make a detour to safer places (funding, publishing, training).⁹

We believe that the neurosciences, combined with the cognitive sciences, are the latest temptation.

Responding to the invitation to reflect on the present state of the clinical profession we have brought out the “hard” issue represented by the problem of a *conception* and a relational *method* of the clinical intervention. We have also chosen as our clinical subject (or “genre” as we prefer to call it) the consultation with the couple, so as to have a concrete parameter of reference.

The conception concerns a theory of action seen as a drama in which the partners participate in person, but which they also share with the previous generations. The couple in fact is not auto-referential but is a point where the bond with the other interlocks and develops.

Hence the clinical construct of the “couple’s pact” indicating the presence of bonds characterized by conviviality, but also of “anti-pacts” featuring rancour and relational perversion.

⁷ On this see the tool of the “Images of couple’s needs”, or that of the “Image of the bond with the other” (cfr. Cigoli et al., 2005a).

⁸ We have identified three fundamental modalities of bonds in the couple characterized by *reciprocity*, by *assimilation*, and by *sharing out*.

⁹ Cfr. The editorial “*In praise of soft science*”, in “Nature”, 435, 7045, p. 1003 (23/06/2005). The term “training” is about practising to achieve pre-established goals. Education (“Formation”) is on the other hand characterized by a process of de-formation and trans-formation.

This gives rise to clinical attention that is not confined to considering the partners' interactive modalities and the cognitive-affective aspects of the exchange, but is also open to the ethical dimension which is considered the energy of the action.

The evaluation of the process of care is also affected by this dimension. It is as if all those who make up the "working group" (couple and clinicians) had to answer the question: what responsibility do you take concerning feelings and actions towards the other? What could, and can, each person do to promote the bond, this third entity, so fine and delicate, but crucial for relations between humans?

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