Shades of Witmer: the demand for Clinical Psychology between continuity and change

by Roberto Vitelli*

1. Introduction

The centenary of the publication of the first Clinical Psychology journal, *Clinical Psychology*, founded by Lightener Witmer in 1907, provides an opportunity to reconsider the present situation and the future prospects of the discipline which was given its name by Witmer. Despite its apparent remoteness both in time and in the geographical area of its production, the journal's introductory article, signed by Witmer himself, may be a good starting point. Organizing a discourse on the "demand for Clinical Psychology between continuity and change" necessarily entails, in fact, preliminary reflection on the *historical a priori* related to the two terms used: "demand" and "Clinical Psychology". If, as Foucault wrote, "man is not a contemporary of his own being" (1966, p. 360), it is necessary to ask oneself which specific *discursive practices* give rise to the development of the issue of the demand, and also of the idea of a *"Clinical Psychology".* Returning to Witmer and studying his text does not have so much the sense of a mere reference to a linear historiography; rather, it involves the attempt to define the field in which the question of the *Demand for Clinical Psychology* found, and still finds, a concrete possibility of being expressed, along with its limits and its prospects. The speaker, in fact, far from having a total grip on his own discourse, relies on the field of expression for the form it will take: *"it is the positivity of the discourse that makes up the historical a priori within which both objects and subjects are constituted*" (Sorrentino, 2005, p.XXIII). What is at stake, in particular at this moment in history, is not something trifling. What is involved in the issues underlying the question about the present and future of Clinical Psychology is not only what makes up the specific discipline and its range of action, but also the various ators involved: the professionals and those who go to them for help.

2. The Clinical Method

As we know, it is on a highly pragmatic level and above all with an eye turned towards Medicine that Clinical Psychology sees its origins as an autonomous discipline. Traces of the deep bond between it and Medicine are in fact present in the name itself, in the use of the term "clinical", justified as follows by Witmer in his opening article:

"[…] talking about the association of Clinical Psychology and psychological clinic may undoubtedly lead to a series of contradictions in terms related to the most varied topics. While the term "clinical" has been borrowed from medicine, Clinical Psychology is not a medical psychology. I borrowed the term "clinical" from medicine because it is the best term I could find to indicate the specificity of the method that I suppose is necessary in this work. Words rarely retain their original meaning and clinical medicine is not what the word implies – the doctor working at the patient's bedside. The term "clinical" entails a method and not a place […]".

Not Medical Psychology, then, or Psychology applied to problems of Medicine as a set of knowledge and practical skills that the doctor should know and use in his profession, or questions of method. A little further on, in fact, the author refers to Boerhaave, the famous Dutch doctor who lived at the turn of the 17th and 18th centuries. Boerhaave is one of the fathers of modern medicine, the founder of what he himself called *Praxis Medica*, or the careful study of the single case conducted in the light of

* Affiliate Professor of Clinical Psychology. Clinical Psychology and Applied Psychoanalysis Unit. Department of Neuroscience, "Federico II" University of Naples.

available knowledge of physiology and physiopathology. Witmer therefore seems on the one hand to be referring to what would later be called the ideographic approach, that is, the approach to the individual case, while on the other hand he underlines the more general meaning to attribute to the nascent discipline: that of a highly applicative form of psychological science, of placing at the disposal of real life everything psychologists had up to then learnt and formalized, starting from laboratory results. It is well known that the new form of psychology proposed by Witmer was regarded by official Psychology with scepticism if not with open hostility: a concrete application was considered an aberration, something that was going to contaminate the aseptic purity of the laboratory (Reisman, 1991). To give the historical contextualization, we are in the early 1900s: these were the years when a part of psychiatry, having definitively abandoned Pinellian and Esquirollian theories, was increasingly basing itself on the work and thought of Kraepelin, on his nosographic systematization of *mental illnesses* with the inevitable corollary of the disappearance both of the *knowing subject* and of the *patient* with his own particularities. At the same time, psychoanalysis, taking up what it had inherited from hypnosis and the cathartic method, reintroduced the subject and his/her particular history, producing a knowledge and a practice that was still, however, organized from a psychiatric standpoint. The new-born Psychology[1], started to expand its interests: in those same years, major authors produced some of their most influential works: William James had recently published, in 1890, his "Principles of Psychology"; Galton, the eclectic, but also decidedly questionable, genius introduced the use of statistics in Psychology; in the same year as James's masterpiece, Cattell published his "V.- Mental Tests and Measurements" (Cattell, 1890)[2]. Medicine, on the other hand, was slowly starting to move in the direction of forgetting the *subject* which would increasingly characterize it in the name of the objectivity of clinical data, the importance of the reliability of acquired knowledge and the real efficacy of the treatments proposed, and of the unconditional faith in technical instrumentation. In the neurological field, in particular, in spite of the many advances made at the level of knowledge[3], the possibilities of successful intervention often proved to be rather limited and it was, in a sense, precisely due to this *lack* that Clinical Psychology made its first moves. There are two well-known stories reported in the literature about the motivations that pushed Witmer to put forward a view of Psychology in a field defined by the instrumental, operative character of knowledge-getting processes that deferred to the curative needs of specific problems, on the borderline between psychic and somatic: the first story, told by Witmer himself (Witmer, 1907), traces the origin of his interest to his years teaching in a prep school and the difficultiies encountered with one of the pupils, showing detarded development of language functions (written, spoken and comprehension abilities), which seemed to him not adeqautely diagnosed and treated; the second story was told by Robert Brotemarkle (1947), Witmer's colleague and friend, who said that Witmer was invited by an acquaintance of his, a teacher in the public school, to use the knowledge in his possession to

[1] As we know, Psychology's birthdate is generally indicated as being 1879, the year the first laboratory of Experimental Psychology was founded at Leipzig by Wundt. The beginning of Clinical Psychology, is usually dated at 1896, the year Witmer, who had trained at Leipzig with Wundt, founded the first Clinic and first began teaching Clinical Psychology at the University of Pennsylvania.

[2] This historical reconstruction is obviously approximate and incomplete. For a fuller vision of the historical panorama in which Clinical Psychology was first set up, cfr. Reisman, 1991 and Lombardo & Foschi, 1999.

[3] At the beginning of the 1900s, neurology was already quite a consolidated discipline in the corpus of knowledge. In the 20th century in fact the study of the anatomy and physiology of the brain had received a great incentive thanks to the work of authors like Franz Joseph Gall, Pierre Flourens, Paul Broca, Karl Wernicke, Gustav Fritsch and Eduard Hitzig, David Ferrier, Jean-Martin Charcot, Theodor Schwann, Theodor Meynert, Camillo Golgi, Charles Sherrington and Santiago Ramòn y Cajal (Civita, 1999). The rapid succession of discoveries in this field led Griesinger (1817-1868), in the adjoining field of the emerging Psychiatric Science, to declare that "mental illnesses are illnesses of the brain" (Wilson, 1993). The correlation between syphilis and progressive paralysis, the discovery of the effects produced by some specific nutritional deficiencies on psychic functioning with major psychiatric symptoms and damage to the central nervous system, as well as the research of Jacques-Joseph Moreau of Tours on the effects of hashish, contributed to theorizing a biological origin of mental illness, opening the way to the organistic lines of thinking that are still extremely active in psychiatric thought.

promote an improvement of the greatly impaired abilities of one of his pupils. Having decided to look into the case, Witmer discovered that the boy actually suffered from primary vision impairment. After correcting this problem and taking care of the pupil, he managed after a while to bring about a clear improvement in the dyslalia for which he had initially been consulted. Struck by the success he had obtained, he decided, says Brotemarkle, to study the topics related to the diagnosis and treatment of those conditions for which it had seemed that Medicine was unable to provide a remedy or, at any rate, did not have the right tools and knowledge to intervene effectively.
Now, it matters little what happened exactly, that is, whether it was his pupil or the pupil of a friend is not important: in both versions of the story, what is clear is that the *deficiency*, the *gap in Medical Knowledge and Techniques*, was the original source from which Clinical Psychology began and developed.

3. Clinical Psychology and Medicine: convergences and divergences

Far from being seen as a mere place of origin, being part of the *medical field* seems to have left a deep imprint on the very nature of Clinical Psychology, which during its history has produced a series of effects, mainly implicitly assumed and not often discussed in the current literature: the psychotherapeutic moment, nearly unanimously acknowledged as the backbone of the Discipline[4], constitutes a manifest sign of this membership. If the "treatment" of psychic malaise, in the sense of *therapy*, is the aspect most typical of Clinical Psychology, the question of claiming territory and staking out boundaries with Psychiatry arises spontaneously. But is this the only possible incarnation of Clinical Psychology? And must psycho-therapy be exclusively viewed in the way just indicated? Isn't there the need anyway for careful surveillance of the *implicits* and of the *discursive strategies* that in are the background of such practice? These are complex questions which we will try to answer. But before doing so, perhaps we should try to express these implicits better: only by starting from such an analysis can we in fact try to provide an answer, albeit provisional, to the question about the present and future of the discipline. It is not easy, due to the very fact that, as we have said, the possibility of producing any statement, and therefore the concrete possibility of defining the profession and the individual subjects involved in it, seems to be conditioned by this membership: disowning it may weaken the discourse, when the logic guiding and supporting it risks breaking down as soon as it is questioned again.
In the same opening article mentioned earlier, Witmer writes:

" […] the clinical psychologist, as a researcher, sets himself the aim of discovering the relation between cause and effect …. as far as the methods of Clinical Psychology are concerned, they are involved each time an individual's state of mind is modified through an intervention carried out via observation, experiment and pedagogic treatment that leads to a change, namely the development of this individual's mind".

While referring to the clinical method, as we have just said, implied an ideographic approach, the epistemological direction involved in the scheme of thought presented here appears more difficult to

4 It is worth giving the full definition of the domains of Disciplinary Competence, as formulated by the College of Professors and Researchers in Clinical Psychology of Italian Universities (2003). "Clinical Psychology is a sector of psychology whose objectives are the explanation, the understanding, the interpretation and the reorganization of dysfunctional or pathological individual and interpersonal mental processes, together with their behavioral and psychobiological correlates. Clinical Psychology can be identified with the psychological methods designed for consultancy, diagnosis, therapy or intervention in the individual psychological structure and organization, in its problematic aspects of suffering and maladjustment and in its interpersonal, social and psychosomatic reflections. Clinical Psychology is also designed for interventions to improve socio-psycho-biological well-being and related behaviors, including prevention, in the various clinical and environmental situations. *In its different strategies and methods, psychotherapy is the domain of application most typical of Clinical Psychology, as the highest point of convergence between demand, available psychological knowledge, phenomena investigated and methods that can be used*" [our italics].

define. In particular, stating the need for Clinical Psychology to *identify the relations between cause and effect* in its operation would seem at first sight to suggest a sort of reconciliation of the cognitive methods typical of the Sciences of the Spirit, (*Geisteswissenschafften*) based on *verstehen*, on understanding, with those typical of the Sciences of Nature (*Naturwissenschafften*) based, instead, on *erklären*, on explaining; this would come about through the identification of a special, singular relationship between certain phenomena, apart from their dependence on a universal law. On a closer reading, however, Witmer's discourse seems to contain the echo of that self-definition of the young Psychological Science which, by claiming a place for itself in the "strong sciences", detached itself definitively from the old "rational psychology" with its philosophical imprint, thus seeking legitimation as a scientific discipline. The declaration of the practice of psychology in a pedagogical sense, anticipating the conception of psychotherapy interventions as tools designed to correct a deficit, rather than promoting growth in the relationship between individual and context (Carli e Paniccia, 2005; Carli, 2007a; 2007b; Pazzagli e Benvenuti, 2006), seems to be moving in this direction. It is not therefore so much an attempt to reconcile two domains formalized by Dilthey[5]: the declaration of intent seems instead to be that of a (lethal?) embrace with the Sciences of Nature.

4. A question of names ….

If *psycho-therapy* is the proper incarnation of Clinical Psychology, that is, if intervening in *mental distress* is its key-stone, it seems almost inevitable to assume what psychiatry for over two hundred years has been describing, cataloguing and above all, reifiying: mental distress, itself. The *treatment* will set out to correct the deficits or imbalances affecting the affective and intellectual fields, or perhaps to modify specific cognitive-affective-behavioral patterns so as to achieve a better adaptation in social, affective, working life, and so on. If today, as Edgar Morin said a few years ago, "the aspiration for individual happiness is becoming a need" (Morin, 1962, p.82), if productivity and the capacity to be part of the production-consumption circuit is the only absolute value in judging the individual, the task of Clinical Psychology will be to promptly recuperate the "subject" for society, to re-insert him in the "recreational-aesthetic" circuit so perceptively desribed by Martin Heidegger in his characterisation in *Das Man*, of the anonymous, impersonalized 'the they'[6]. Research in Clinical Psychology will then focus each time on "Panic Attack disorder", on "Eating disorders", and so on, with the final aim of obviously strengthening the strategies of "care". Now, what is at issue here is not so much the legitimacy of all this: we do not want to challenge the existence or the seriousness of the "suffering" of the soul and the forms that this can take, or the necessary ways of relieving it. The issue concerns a call for surveillance and, why not, for the unmasking of the tricks, the strategies and the effects that in the actual state of things, can support a "certain" "therapeutic culture" (Rovatti, 2006).
Emmanuel Kant wrote: "There is a kind of doctor, the doctors of the mind, who whenever they find a name, think they have found an illness" (1764, p. 59). In this statement the philosopher of Königsberg was referring to the operation that underlies the whole field of psychiatric knowledge, namely the action of naming, which moreover is the result of the specific position producing it: the field of Science. It is this operation that leads to looking at and understanding psychic distress on the same plane as a

[5] As we know, at the end of the 1800s, Wilhelm Dilthey, in his *Introduction to the Sciences of the Spirit* (1883), systematized the difference between the gnoseological procedures typical of the two different domains: on the one hand, the Natural sciences, based on *erklären*, on the explanation of the determining cause of events, and on the other, the Sciences of the Spirit (i.e. Historical Sciences) based on *verstehen*, on understanding "from within" the "human" facts/events achieved by starting from the internal states of the knowing subject.
[6] With a brilliantly perceptive questioning of the current age, Heidegger said of that anonymous, homogenizing dimension he called *Das Man*, 'the they', the modality most typical of inauthenticity: "we have fun and enjoy ourselves as one enjoys oneself; we read, we look and we judge literature and art as one looks and judges. We keep away from the "great mass" as one keeps away, we find scandalous what one finds scandalous. 'The they', which is not a a particular being, but everybody (not however in total) decrees the way of existing of daily life (Alltëglichkeit)" (Heidegger, 1927, p. 163).

specific, homogeneous, and therefore cataloguable, *natural entity*. Now, however often it is regarded with suspicion or openly criticised, this seems to be the operation underlying most of the whole area of research, teaching and the practice of clinical psychology[7].
The adoption of medical-psychiatric nosography, which to some might seem inevitable given the need to use a common language in the "scientific community", is not however an operation that is *neutral* in itself, an option like others. This is so if one considers that the act of naming produced by Psychiatric Knowledge has inevitable effects on the processes of *subjectivization* within a given socio-historical context. The act of naming in fact is situated inside the network of institutions and practices from which the *"madman"* is *taken and labelled*: "it is the identity itself of the single individual that is defined through being ill and therefore needing care. And it is the individual himself that finds in the therapeutic culture that studies him, all the discursive elements (with their practical and social effects) to construct his own identity as a subject" (Rovatti, 2006, pp.26-27). It is therefore not only that "the psychic symptom is transformed, meek and cooperative towards social changes" (Lolli, 2005, p.8), it is the performative nature of Word Acts that produces major effects on the processes of subjectivization through the various mediators given each time: television, newspapers, university lecture-halls and so on[8]. Obviously what we should therefore demand today is careful monitoring, a thorough and conscious use of this set of conceptual tools, which are anything but neutral. Or perhaps, in a more radical way, the time has come to say goodbye to psychiatry with a determined, courageous act, taking the "patients, or the bearers of suffering", along other paths or processes of subjectivization, beyond the logic of *Same* and *Different*, which Foucault placed at the origin of psychiatric Knowledge-Power (Foucault, 1966).

5. Medicine, gaps and deficiencies …

Besides the complex relationship with psychiatry, there is another side to the relations between Medicine and Clinical Psychology which, though absent from Witmer's discourse, today seems particularly important, above all as a possible future scenario. Clinical Psychology today seems to be called to a sort of new passage towards the places of origin, starting from the *deficiencies* in medical *Knowledge* and *Technique*. Karl Jaspers' appeal for Medicine to recover its humanitarian components (1986) having fallen on totally deaf ears, the place reserved for Clinical Psychology in the *Pratice* typical of that *Knowledge* seems to be in the slot left empty by Medicine itself: this slot concerns *sense* and *meaning*. Re-reading the German physician/philosopher's writings between 1950 and 1955 reveals, in fact, that he did not fully understand the irreversability of a process that still configures medicine as a branch of Knowledge based on an almost total technicization of its operations, and therefore on a almost radical exclusion of the perspective of *sense*. If it is true, as Umberto Galimberti writes in reference to Jaspers (1986), that "when there is any illness, the order of my existence is turned totally upside-down, which is not a side-effect to add to the illness as its inevitable <<psychological consequence >>, but which is actually its essence" (2005, p.284), then such a turning upside-down is not something the doctor will be able to deal with, at least judging by the scenario that

[7] Obviously, there are many critical voices on this issue: just to take one, that of Alessandro Salvini: "… from psychoanalysis to cognitivism, metaphorical concepts like "structure", "stages", "phases", "patterns", "networks", "pressures", "pathologies" are thought of as psychical entities that really exist, giving them explicative power, but along the way losing their "as if", their metonymic ambiguity, and their analogical nature" (Salvini, 2007, p.23).
[8] This is the direction in which one should read the veritable explosion of cases of mental anorexia, as well as the growing number of demands for sex-changes in relation to general states of dysphoria: what role has been played and is still being played by the constant reiteration in the mass media of such specific forms of existence in subjectivization processes? Note however that what is being proposed here is not a re-hash of the simplistic sociological interpretation of mental illness or of an approximative foucaoultian interpretation of the problem; the point is to look at the boundaries between individual and context which have a profound indirect effect, through a complex coordination of intrapsychic matters.

is visible to all today[9]. The direction that Medicine seems to have taken, in fact, despite the repeated appeals for re-thinking its operation (e.g., Lown, 1999), seems to be essentially very difficult to change. Biological reductionism, technicization, the reliance on the order of *erklären*, the mechanical model of illness (Wulff, et al., 1986), the de-personalization of the doctor-patient relationship, are almost a sort of inevitable corollary to the progress achieved.
One answer to the qustion of the *present demand for Clinical Psychology* can therefore perhaps be found in the demand for *sense*, but it seems that today this demand will (can) be answered by Philosophy.

6. Clinical Psychology between Positivist-Empirical Sciencea and Philosophical-Hermeneutic Science: sense, meaning, prospects.

In the section specifically devoted to expressing thanks in his latest book "psychopathology of common sense", Giovanni Stanghellini, with reference to the world of psychiatrists, writes that "no more than a few years ago, many of us felt a kind of embarrassment, some even shame, in admitting our interest in an area still clandestine and unclear like the relationship between 'philosophy and psychiatry" (Stanghellini, 2006, p.3). In effect, the imperious advance of biological-reductionist attitudes in psychiatry seems now on the rebound to have produced the need in psychiatry for a fresh, stringent dialogue with the philosphical disciplines[10].
While it is true at this point that Clinical Psychology, too, has never stopped looking, shamefacedly and furtively, at its ancient "cousin", it is also true that it seems in the grip of two opposing tendencies: on the one hand there is the forceful vindication of its own "scientific" character and therefore the adoption of an inflexible *mathematicization of the human*, perhaps as an essential safeguard against a dangerous "metaphysical" drift or more simply as an affirmation of its own right to existence as a "scientific discipline"; on the other hand, there is the uneasiness caused by the emergence of practices, in themselves rather ambiguous, that are generically considered philosphical practices[11]. The two things, moreover, seem to be the mirror of each other.
The claim for the scientific nature of the discipline, essentially supported by the reference to the law of numbers, and by the rigorous use of statistics as the only possible way of producing statements with a sufficient degree of approximation to the "truth of things", actually more often seems unable to provide an adequate response to *clinical* needs. On the other hand, it appears that due to this inability, Philosophy is claiming new spaces for itself. If all this is true, when faced with what is considered Philosophy's unjustified *invasion of the field* (cfr. for example, Grasso, 2006), actually legitimated by those more extreme expressions of Philosophical practices called, in the literature, philosophical counseling or therapeutic philosophy (Neri Pollastri, 2006), rather than defending its own boundaries and the correct attribution of competences to the various fields of Knowledge, it would be useful to ask oneself whether what is happening should not be put down to the original choice of allegiance, the

[9] On this point it should be pointed out that today a double phenomenon can actually be seen: on the one hand, the Physician seems to have forgotten the ancient Hyppocratic saying "iatros philosophos isotheos" ("the physician who becomes a philosopher – or lover of wisdom – is like a God"), since the time devoted for example to Psychology in the Medical degree course is insignificant overall; on the other hand, an increasing amount of time is devoted to it in the Health Studies degree courses, which seems to suggest a new shift towards attributing specific psychological "competences" to the new emerging professional figures; nurses, but also dietitians, speech-therapists, etc. This operation in some cases, however, while certainly being important, seems to bring with it the need for particular caution in view of the possible imaginary attribution/assumption of a purely fictitious knowledge.
[10] As a matter of fact, it must be said that in some specific, fertile areas of psychiatric territory, this dialogue has never been broken off. Think of the phenomenological approaches.
[11] Rovatti himself sees in many forms of philosophical consultancy an essential ambiguity that ends up introducing such practices into the same "care circuit", a domain already long occupied by clinical psychologists, counsellors, psychotherapists, etc. (Rovatti, 2006).

originial positioning, defended with growing energy, as part of the Sciences of Nature. In fact, isn't philosophy trying to respond to a specific social demand to which Clinical Psychology does not seem able to satisfy in full? Is it not in response to a *Demand for Sense* that philosophical practices, as it were, are developing (Rovatti, 2006; Brentari, 2006)? If the "incredulity in the meta-narrations", as Lyotard (1979) wrote, or the challenge to the traditional systems of values, rules, stories, which sustained science, literature and the arts for centuries, at least up to the beginning of the 20th century, characterizes the post-modern condition, the feeling of being lost may actually constitute the sign of current times, perhaps also expressed in a clinicial sense. But if this is true, there must necessarily be a re-thinking of one's practices, as well as, why not, of one's reference points. If for instance, as we said above, beyond its often tired and empty rhetoric, Medicine is not able to fully account for the "meaning of the illness event", since the only real anchorage for its operation is the biological paradigm, and if it is true that Clinical Psychology is today called to fill the slot left vacant by Medicine, isn't it time for a new coordination of psychological knowledge with that of philosophy, that is, with those whose *raison d'être* is precisely asking questions about meaning, time and the finiteness of existence? This is a courageous, and probably unfashionable, choice, but it is not impossible in an absolute sense: psychoanalysis, systemic thought, interactive-constructivist approaches, some forms of clinical cognitivism, obviously as well as the existential humanistic approaches, have always carried on a fertile dialogue with their ancient cousin. In particular, about psychoanalysis, as Meletis Meletiadis reminds us:

"[…] when it does not claim to be the new religion, that is, a total conception of man and of the world, all it does is deal with the variety of Words, with the problems of the living being, of passages and no-through roads, with anger and pain, with the paralysis of the mind and the labyrinths of reason. That is why the relation between philosophy and psychoanalysis is so close that they feel either like sisters or enemies; they are either so attracted they become one, or they hate each other so much that they exclude each other totally. Both, in studying the how and the why, examining in depth ways of living, with their tendency to solve the insoluble, to bring light to the depths of ignorance, orthodoxy to the distortion of subjectivism, seeking if not producing meaning for every thing and for all existence, believe they are in the driver's seat of the human soul; both want to lead man from the path of not being to that of being, of truth; they aim to educate him in a mode, in a life practice, in taking a stance before the world …. Pyschoanalysis is first of all, directly or indirectly, a therapeutic practice. Its aim is not the search for a painless, insensible situation, for baseless happiness, but the discovery of a sense of life, in the sense of living with life, whether it is full of joy or of pain and upsetting feelings […]" (Meletiadis, 2006, pp.104-106).

These are questions of ethics, questions of praxis, that are perhaps actually terribly "irrelevant" today. On the other hand, like Nietzsche, what we are probably left to do today is to respond and act "in an irrelevant way – namely against time, and therefore in this way to affect time and, hopefully, in favour of a time to come" (Nietzsche, 1874; p. 5).

Bibliography

Brentari, C. (2006). La domanda di filosofia nel mondo contemporaneo. In C. Brentari, R. Màdera, S. Natoli & L. Vero Tarca (Eds.), *Pratiche filosofiche e cura di sé* (pp.239-244). Milano: Paravia Bruno Mondadori.

Brotemarkle, R. (1947). Clinical Psychology: 1896-1946. *Journal of Counsulting Psychology*, *11*, 1-4.

Carli, R. (2007a). Proposte per una definizione degli obiettivi della psicologia clinica: Correggere deficit o promuovere sviluppo. In E. Molinari & A. Labella (Eds.), *Psicologia Clinica: Dialoghi e confronti* (pp.3-20). Milano: Sprinter-Verlag Italia.

Carli, R. (2007b). Psicoterapie Psicodinamiche. In E. Molinari & A. Labella (Eds.), *Psicologia Clinica: Dialoghi e confronti* (pp.67-75). Milano: Sprinter-Verlag Italia.

Carli, R., & Paniccia, R.M. (2005). *Casi clinici: Il resoconto in psicologia clinica.* Bologna: Il Mulino.

Civita, A. (1999). Neuroscienze e malattia mentale. In A. Civita & D. Cosenza (Eds.), *La cura della malattia mentale: storia ed epistemologia* (pp.30-88). Milano: Bruno Mondadori.

Cattell, J. McK. (1890). V.-Mental Tests and Measurements. *Mind*, 15, 373-381. Retrieved September, 24, 2007 from http://psychclassics.yorku.ca/Cattell/mental.htm.

Collegio dei Professori e dei Ricercatori di Psicologia Clinica delle Università Italiane (2003). Ambiti di Competenza Disciplinare. In E. Molinari & A. Labella (Eds.), *Psicologia Clinica: Dialoghi e confronti* (pp.315-316). Milano: Sprinter- Verlag Italia. Retrieved September, 24, 2007 from: http://www.collegiopsiclinicauniv.it/ita_ambiti.htm.

Foucault, M. (1966). *Les mots et les choses: une archéologie des sciences humaines*. Paris: Gallimard (trad. it. *Le parole e le cose: Un'archeologia delle scienze umane*, Rizzoli, Milano, 1998).

Galimberti, U. (2005). *La casa di psiche: dalla psicoanalisi alla pratica filosofica*. Milano: Feltrinelli.

Grasso, M. (2006). Chiodi, unghie e martelli: annotazioni sparse sull'oggi della psicologia clinica. *Rivista di psicologia Clinica,* 1, 3-18. Retrieved September, 24, 2007 from: http://www.rivistadipsicologiaclinica.it/italiano/numero1/Grasso.htm.

Heidegger, M. (1923). *Sein und Zeit*. Tübingen: Max Niemeyer (trad. it. *Essere e Tempo.* Longanesi & C., Milano, 1976).
James, W. (1890). *Principles of Psychology* (2 vols.). New York: Henry Holt (Reprinted Bristol: Thoemmes Press, 1999). Retrieved September, 24, 2007 from: http://psychclassics.yorku.ca/James/Principles/index.htm.

Jaspers, K. (1986). *Der Arzt im technischen Zeitalter*. München: Piper (trad. it. *Il medico nell'età della tecnica*. Raffaello Cortina, Milano, 1991).

Kant, I. (1764). Versuch über die Krankheiten des Kopfes. In Werke, Bd. II, S. 301-316.50 (trad. it. Saggio *sulle malattie della mente*. Ibis, Como-Pavia, 1992).

Lolli, F. (2005). *L'ombra della vita: psicoanalisi della depressione*. Milano: Bruno Mondadori.

Lombardo, G.P. & Foschi, R. (1996). *Studi di storia della psicologia*. Roma: Kappa.

Lown, B. (1996). *The lost art of healing*. New York: Ballantine Books (trad. it. *L'arte perduta di guarire*. Garzanti, Milano, 1997).

Lyotard, J.-F. (1979). *La condition postmoderne*. Paris: Minuit (trad. it. *La condizione postmoderna: rapporto sul sapere*. Feltrinelli, Milano, 1985).

Meletiadis, M. (2006). Aspetti comuni dei luoghi della filosofia, della teologia e degli atti psicoanalitici nella cura di sé. In C. Brentari, R. Màdera, S. Natoli & L. Vero Tarca (Eds.), *Pratiche filosofiche e cura di sé* (pp.104-113). Milano: Paravia Bruno Mondadori.

Morin, E. (1962). *L'esprit du temps: essai sur la culture de masse*. Paris: Grasset (trad. it. *Lo spirito del tempo.* Meltemi, Roma, 2002).

Nietzsche, F. (1874). *Unzeitgemasse Betrachtungen. Zweites Stuck Vom Nutzen und Nachteil der Historie fur das Leben. Gesammelte Werke. 23 voll.* Muenchen: Musarion Verlag. (trad. it. *Considerazioni inattuali: Sull'utilità e il danno della storia per la vita. II.* Adelphi, Milano, 1973).

Pazzagli, A. & Benvenuti P. (2006). Per una psicologia del patologico. *Rivista di Psicologia Clinica*. 2-3, 2006. Retrieved September, 24, 2007 from:http://www.rivistadipsicologiaclinica.it/italiano/numerocorrente/Pazzagli_Benvenuti.htm.

Pollastri, N. (2006). La consulenza filosofica come “pura” filosofia. In C. Brentari, R. Màdera, S. Natoli & L. Vero Tarca (Eds), *Pratiche filosofiche e cura di sé* (pp.168-186). Milano: Paravia Bruno Mondadori.

Reisman, J.M. (1991). *A history of clinical psychology*. New York: Hemisphere Publishing Corporation. (trad.it. *Storia della Psicologia Clinica*, Raffaello Cortina, Milano, 1999).

Rovatti, P.A. (2006). *La filosofia può curare?* Milano: Raffello Cortina.

Salvini, A. (2007). La reificazione come rischio in psicologia clinica. In E. Molinari & A. Labella (Eds.), *Psicologia Clinica. Dialoghi e confronti* (pp.21-27). Milano: Sprinter-Verlag Italia.

Sorrentino, V. (2005). Le ricerche di Michel Foucault. In M. Foucault, *Antologia* (pp. VII-LV). Milano: Feltrinelli.

Stanghellini, G. (2006). *Psicopatologia del senso comune*. Milano: Raffaello Cortina.

Wilson, M. (1993). DSM III and the transformation of American psychiatry: a history. *American Journal of Psychiatry*, *150*, 399-410.

Witmer, L. (1907). Clinical Psychology. *Psychological Clinic*, *1*, 1-9. Retrieved September, 24, 2007 from http://psychclassics.yorku.ca/Witmer/clinical.htm.

Wulff, H.R., Pedersen, S.A. & Rosenberg R. (1986, 1990), *Philosophy of Medicine*. Oxford-London-Edinburgh: Blackwell Scientific Publication (trad. it. *Filosofia della medicina*. Raffaello Cortina, Milano, 1995).